

VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Date _____

Patient Name _____

Date of Accident _____ Time of Accident _____ a.m.

p.m.

Please describe the accident in your own words: _____

Were you the: Driver Front Passenger

Rear Passenger

Pedestrian

How many people were in the accident vehicle? _____

ACCIDENT SITE

Road/Street Name _____

City/State _____

Nearest intersection with road/street _____

Driving conditions Dry Wet Icy Other _____

Which direction were you headed? _____

Speed you were traveling? _____

IMPACT

Did your car impact another vehicle? Yes No

Did your car impact a structure? Yes No

If yes, explain _____

Did any part of your body strike anything in the vehicle?

Yes No If yes, explain _____

Was impact from:

Front Rear Left Right Other _____

At the time of impact were you:

Looking straight ahead Looking to the right
 Looking to the left Looking down
 Looking up

Were both hands on the steering wheel? Yes No

If no, which hand was on the wheel? Right Left

Was your foot on the brake? Right Left

If yes, which foot was on the brake? Right Left

Were you: Surprised by impact Braced for impact

VEHICLE

Make and model of vehicle you were in:

Were you wearing a seatbelt? Yes No
If yes, what type? Lap Shoulder

Was vehicle equipped with airbags? Yes No
If yes, did it/they inflate properly? Yes No

Did your seat have a headrest? Yes No
If yes, what was the position of the headrest?
 Low Mid-position High

OTHER VEHICLE

(If applicable)

Make and model of other vehicle _____

Which direction was other vehicle headed? _____

Speed other vehicle was traveling? _____

OTHER VEHICLE

Did the police come to the accident site? Yes No

Were there any witnesses? Yes No

Was a police report filed? Yes No

Was a traffic violation issued? Yes No

If yes, to whom? _____

PATIENT CONDITION

Were you unconscious immediately after the accident? Yes No If yes, for how long? _____

Please describe how you felt immediately after the accident:

TREATMENT

Did you go to the hospital? Yes No

When did you go? Immediately after the accident

Next Day

2 days or more after the accident

How did you get to the hospital?

Ambulance

Private transportation

Name of hospital _____ Name of doctor _____

Diagnosis _____

Treatment received _____

X-rays taken _____

SYMPTOMS/INJURIES

Have you been able to work since this injury? Yes No How many work days have you missed? _____

Prior to the injury were you able to work on an equal basis with others your age? Yes No

If you have had any of the following symptoms since you injury, please check:

- Arm/shoulder pain
- Back pain
- Back stiffness
- Chest pain
- Dizziness
- Ear buzzing
- Ear ringing
- Fatigue

- Feet/toe numbness
- Hand/finger numbness
- Headaches
- Irritability
- Jaw problems
- Leg pain
- Memory loss
- Nausea

- Neck pain
- Neck stiff
- Shortness of breath
- Sleep difficulty
- Stomach upset
- Tension
- Vision blurred

Is this condition getting progressively worse? Yes No Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain:

- Sharp
- Aching
- Cramps

- Dull
- Shooting
- Stiffness

- Throbbing
- Burning
- Swelling

- Numbness
- Tingling
- Other _____

How often do you have this pain? _____

If the pain frequency Occasional Intermediate Frequent Constant

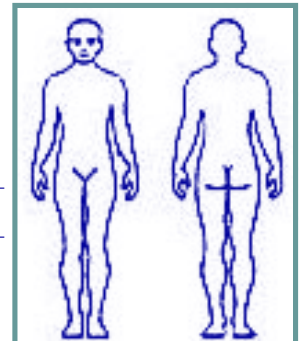
Does it interfere with your: Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform:

- Sitting
- Bending

- Standing
- Lying down

Walking



I certify that the above information is correct to the best of my knowledge.

Patient Signature _____ Date _____