Accident Report

Name_____ Date of accident _____ Time_____ ☐AM ☐PM

Location of accident_____ State_____ Witnesses ☐Yes ☐No

Have you lost any time from work: ☐Yes ☐No Give dates: _____

Auto Accident

-Where were you sitting in the car?_____ - # of people in the car: _____
-Were you wearing a seatbelt? ☐Yes ☐No -Type of seat belt were you wearing? ☐Lap Belt ☐Shoulder Harness
-Did airbags deploy at time of impact? ☐Yes ☐No -Did you lose consciousness? ☐Yes ☐No
-Did you hit any body part on the inside of any part of the car? Please Describe: _____
_____
-Where was the head-rest of your seat: ☐Above the ears ☐At level of ears ☐Below ears
-What kind of car were you in?_____ -What kind of car was the other car?_____
-Where were you hit?_____
-At the time of impact where were you looking? ☐Forward ☐Back ☐To the right ☐To the left ☐Up ☐Down
-Road Condition: ☐Wet ☐Dry ☐Ice ☐Snow -Was your car: ☐Stopped ☐Moving _____mph.
-Briefly describe the accident: _____
_____
_____
_____
_____
_____
-How much damage was done to your car, actual estimate given $_____
-Did the police come to the scene of the accident? ☐Yes ☐No -Was a report filed? ☐Yes ☐No
-Was a ticket issued? ☐Yes ☐No If yes, to whom _____

Work Accident

-Please describe what happened: _____
_____
_____
_____
_____
_____
-Who did you report the accident to: _____ -Were there any witnesses? ☐Yes ☐No
-Was an accident report filed and signed by you? ☐Yes ☐No
-What recommendations did your employer make at the time of the accident? _____
_____
-Does your employer know that you came here for an evaluation? ☐Yes ☐No
-Were you given the name(s) of any other doctor? If so, who? _____
-Did you go? If so, when? _____
-Have you had any other work-related accident? ☐Yes ☐No If yes, when? _____
-Please describe: _____

-Did you go to the hospital? ☐Yes ☐No -How did you get there? _____

-When? _____ -Have you seen any other doctor before coming here? ☐Yes ☐No

-What other treatment have you received? _____

-Have you had any x-rays taken or other testing done? _____