ACCIDENT REPORT

Name _____ Date of Accident _____ Time of accident _____ am/pm

Type of injury: auto - work injury - fall - other _____

Where did accident occur, in detail _____

_____

Did weather (ice, snow, rain or lighting, etc) play any part in accident? _____

Describe your symptoms in detail: (circle all that apply)

GENERAL SYMPTOMS

nervousness
irritability
fatigue
depression
loss of sleep
tension
PMS
jaw pain

HEAD

headache □ mild □ moderate □ severe
how often _____ times per day
□ day □ week □ month
are they
□ sharp □ dull □ constant □ intermittent
where located
□ back of head □ forehead □ temples
□ right side □ left side □ behind eyes
light headed
memory loss
blurred vision
double vision
sensitivity to light
loss of balance
hearing loss
ringing in ears

NECK

pain: □ left □ right □ both
□ mild □ moderate □ severe
increased by:
forward movement
backward movement
rotation of head (right/left)
bending of neck (right/left)
stiffness
muscle spasm
grinding/grating sounds

SHOULDERS

pain in joint □ left □ right □ both
pain across shoulder □ left □ right □ both

ARMS

upper arm
pain □ left □ right □ both
pins & needles □ left □ right □ both
numbness □ left □ right □ both
elbow pain □ left □ right □ both
forearm
pain □ left □ right □ both
pins & needles □ left □ right □ both
numbness □ left □ right □ both

HANDS

wrist pain □ left □ right □ both
hand □ left □ right □ both
pain □ left □ right □ both
pins & needles □ left □ right □ both
numbness □ left □ right □ both

MIDBACK

pain □ left □ right □ both
□ mild □ moderate □ severe
spasm □ left □ right □ both
□ mild □ moderate □ severe

CHEST

chest pain □ left □ right □ both
□ mild □ moderate □ severe
rib pain □ left □ right □ both
shortness of breath
irregular heartbeat

ABDOMINAL SYMPTOMS

pain □ left □ right □ both
nervous stomach
nausea
gas
constipation
diarrhea
heartburn
indigestion
loss of appetite

LOWBACK

pain □ left □ right □ both
spasm □ left □ right □ both

HIP AND LEGS

pain in buttocks □ left □ right □ both
□ mild □ moderate □ severe
pain in hip (s) □ left □ right □ both
□ mild □ moderate □ severe
pain down leg (s) □ left □ right □ both
□ mild □ moderate □ severe
knee pain □ left □ right □ both
□ mild □ moderate □ severe
leg cramp □ left □ right □ both

FEET

ankle pain/swelling □ left □ right □ both
foot pain/cramps
numbness/swelling □ left □ right □ both

Are your symptoms (1) getting worse (2) improving (3) same

Have you seen another doctor for these injuries? _____ If so, name _____

Did you have any of these symptoms prior to this injury? _____ If so explain _____

_____

Any Previous Accidents? Yes / No Date(s) of Previous Accidents _____

_____

Time missed from work for previous injury _____

For present injury, have you missed any work? _____ If yes, dates missed _____

Dates of limited work _____ Date returned to full work _____

Were you capable of working on an equal basis prior to this present injury? _____

Are you right or left handed (circle one)?

If the present injury was due to an **auto accident**, were you the driver, passenger front, passenger back, or pedestrian?

other _____

Were you wearing a seatbelt? Yes / No

Type of vehicle: auto, truck, van, motorcycle, motorhome, bicycle (other _____)

How accident occurred: A) struck by another vehicle B) struck another vehicle C) struck a stationary object

D) other _____

Where was your vehicle hit? A) front B) rear C) rt side D) lft side E) rt front F) lft front G) rt rear H) lft rear

Your approximate speed _____ MPH Other vehicle's approximate speed _____ MPH

What occurred at the moment of impact? (Circle as many as apply)

neck forced back & forward spine torqued and twisted cut and bruised thrown from side to side

Did you strike your. . . . .

head (against dash, windshield, steering wheel, right door, left door, seat frame, other)

shoulder (against dash, windshield, steering wheel, right door, left door, seat frame, other)

elbow (against dash, windshield, steering wheel, right door, left door, seat frame, other)

wrist (against dash, windshield, steering wheel, right door, left door, seat frame, other)

hip (against dash, windshield, steering wheel, right door, left door, seat frame, other)

knee (against dash, windshield, steering wheel, right door, left door, seat frame, other)

ankle (against dash, windshield, steering wheel, right door, left door, seat frame, other)

Were you rendered unconscious? Yes / No Did you receive medical attention at scene? Yes / No

Where did you go immediately following accident? Hospital - home - doctor - this office - work

Comments _____

_____

_____

By signing below, I acknowledge that the information given above is true to the best of my knowledge.

_____ _____

Signature Date