ACCIDENT REPORT FORM

Name_____ Date of Accident_____

Name of MPI Adjuster_____ Claim #_____ Time of accident_____:_____ ☐am ☐pm

Do you have MPI coverage? ☐Yes ☐No Does the driver of the vehicle you were in have MPI coverage? ☐Yes ☐No

Have you retained an attorney for the injury? ☐Yes ☐No If yes, name: _____ Phone: _____

Were you the: ☐Driver; ☐Front passenger; ☐Right rear passenger; ☐Left rear passenger; ☐Pedestrian; ☐Cyclist

Vehicle you were in: ☐Car ☐Truck ☐Van Make: _____ Year: _____

Vehicle that hit you or you hit: _____; Their approx. speed: _____km/hour

How much damage was done to your vehicle? _____

The weather was: ☐Clear; ☐Cloudy; ☐Foggy The road conditions were: ☐Dry; ☐Wet; ☐ Icy; ☐Snow Covered

MECHANICS OF ACCIDENT

At the time of the accident were you: ☐Stopped; ☐Moving forward; ☐Moving backwards; Approx. speed: _____km/hour

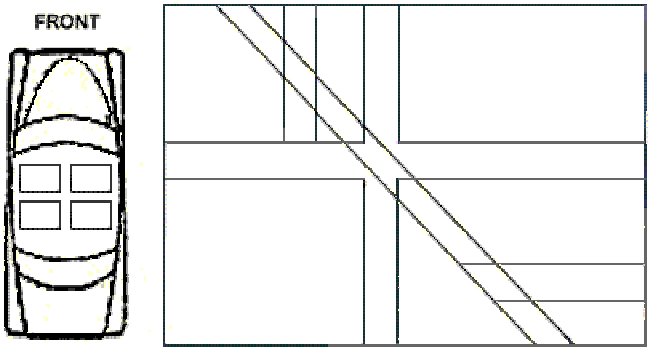
Shade areas of impact & explain in detail the place of the accident and how it happened:_____

_____

_____

_____

_____



Were you struck from: ☐Behind; ☐The front; ☐Left side; ☐Right side

This was a: ☐Head-on collision; ☐Rear-end collision; ☐ "T-bone" collision; ☐Car-bicycle accident; ☐Car-pedestrian accident ☐One car vs. stationary object;

After you were hit did you strike another car or anything else? _____

Were you aware of the oncoming accident? ☐Yes ☐No Did you brace for the impact? ☐Yes ☐No

Were you able to get out and walk? ☐Yes ☐No Did an airbag deploy at your position? ☐Yes ☐No

Were seatbelts in use? ☐Yes ☐No Motor cycle helmet used? ☐Yes ☐No

Does your seat have a high-back or headrest? ☐Yes ☐No If yes, describe the alignment: _____

At the time of accident were you facing or looking: ☐In Mirror; ☐Straight ahead; or were you: ☐turned to left; ☐turned to right

SYMPTOMS AND SUBJECTIVE COMPLAINTS

Did your body strike any particular object: _____

Could you move all parts of your body? _____ Was an ambulance called? ☐Yes ☐No

Did you go to a hospital? ☐Yes ☐No Which one? _____How long were you there? _____

What was done at the hospital: ☐X-rays; ☐Examination; ☐Medication; What kind and what for? _____

What were you told was wrong with you? _____

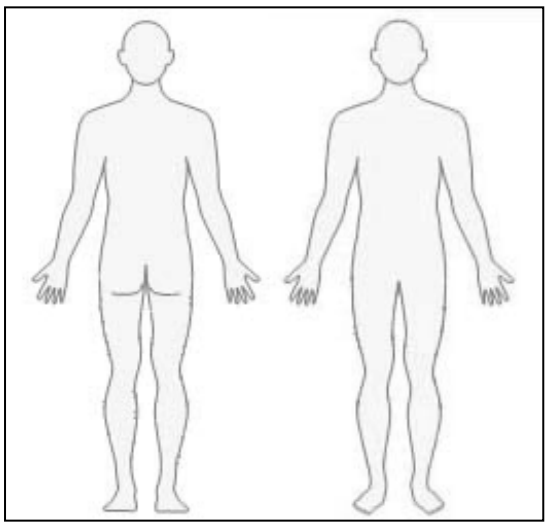
Did the accident happen while you were working on the job? ☐Yes ☐No

Have you seen any other doctors since the accident? (who, when, how often, treatment provided) _____

_____

Have you had x-rays of the injured area: ☐prior to or; ☐since the accident? _____

Please note on diagrams below any area of contusions, bruising, cuts, lacerations, or scrapes:



Have you seen a physiotherapist (who, when, how often, type of treatment)

_____

_____

_____

Before you were injured, were you capable of working on an equal basis with others your own age? ☐Yes ☐No

Have you had any previous car accident or injury in a similar manner?

☐Yes ☐No When? _____

Have you missed work? ☐Yes ☐No

From: _____ To: _____

Did you experience any of the following symptoms after the accident?

Head Injuries
- ☐**Headaches**
- ☐**Loss of consciousness**
- ☐Loss of memory
- ☐Light headedness
- ☐**Disorientation**
- ☐**Confusion**
- ☐Tension
- ☐Fainting
- ☐Eye complaints
- ☐**Blurred vision**
- ☐Lights bother eyes
- ☐Loss of balance
- ☐**Dizziness**
- ☐Loss of hearing
- ☐Pain in the ears
- ☐Ear noises
- ☐Facial muscle disturbances
- ☐Nasal disturbances
- ☐Jaw pain
- ☐Heaviness of head

Neck Injuries
- ☐**Stiffness of neck**
- ☐**Soreness of neck**
- ☐Muscle spasm in neck
- ☐Grinding sound in neck
- ☐Difficulty swallowing

Leg injuries
- ☐**Numbness or tingling in legs**
- ☐Muscle spasm in leg
- ☐Pain in knees, calf or foot
- ☐**Cold feet**
- ☐Painful or swollen ankles
- ☐Pain in hip or buttocks
- ☐Difficulty walking

Shoulder, Arm & Chest Injuries
- ☐Pain in or between shoulders
- ☐Cannot raise arm or hand
- ☐Muscle spasm in shoulders
- ☐**Numbness in arms or hands**
- ☐**Tingling in arms or hands**
- ☐**Cold hands**
- ☐Elbow, finger, or wrist pain
- ☐Shortness of breath
- ☐Rib pain

Lower back symptoms
- ☐Painful tailbone
- ☐**Low back pain**
- ☐**Low back stiffness**
- ☐Difficulty standing erect
- ☐Back aggravated by working, lifting, stooping, sitting, bending, coughing, or lying

General symptoms
- ☐Nervous stomach
- ☐Nausea
- ☐Abdominal discomfort
- ☐Gas
- ☐Constipation
- ☐Diarrhea
- ☐Anxiety
- ☐Depression
- ☐Mood or behavior changes
- ☐Insomnia
- ☐Loss of weight
- ☐Frequent or difficult urination
- ☐Nervousness or restlessness
- ☐Blackouts
- ☐Loss of appetite
- ☐Broken bones
- ☐Increased respiration
- ☐Mental dullness
- ☐Inability to concentrate
- ☐Heart palpitation
- ☐Rapid heart beat
- ☐Tremors
- ☐Twitches

Please list any other daily complaints that have been affected as a result of this accident? _____

_____

Were you suffering any of these symptoms prior to the accident? ☐Yes ☐No If yes, explain: _____

_____

_____

Have your symptoms: ☐improved ☐worsened ☐remained the same

_____ _____

Signature of Patient or Parent/Guardian Date Signed