VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Patient Name: ______________________ Date: ____________

Date of Accident: ____________ Time of Accident: ____________ AM PM

Please describe the accident in your own words: ______________________

____

____

____

Were you the: Driver Front Passenger Rear Passenger Pedestrian How many people were in the accident? ______

ACCIDENT SITE

Road/Street Name: ______________

City: ______________ State: ______

Nearest Intersection with road: ______________

Driving Conditions: DRY WET ICY Other: ______

Which direction were you headed: ______________

Speed you were traveling: ______________

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 ____ MIDPOSITION ____ HIGH

OTHER VEHICLE
(IF APPLICABLE)

Make and Model of other vehicle:

____

Which direction was the other vehicle headed? ______

Speed other vehicle was 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

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? YES NO

If yes, which foot was on the brake? RIGHT LEFT

Were you: ____ Surprised by impact ____ Braced for impact

POLICE

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

If YES, when did you go? ____ Immediately after 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? __________

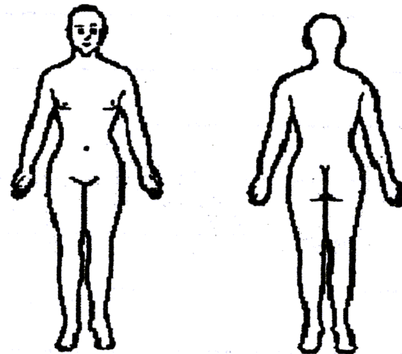
Prior to the injury were you able to work on an equal basis with others your age? ____ YES ____ NO

If you have had any of the following symptoms since your injury, please mark with an _X_:

____ 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 stiffness
____ Shortness of breath
____ Sleep difficulty
____ Stomach upset
____ Tension
____ Vision blurred

Is this condition getting progressively worse? ____ YES ____ NO

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



Rate the severity of your pain: (None) 1 2 3 4 5 6 7 8 9 10 (Most Severe)

Please circle the type of pain you are experiencing: Other ______________

dull aching sharp shooting burning throbbing deep nagging

How often do you have this pain? ____________ Is it constant? __________

Does it interfere with your: ___Work ___Sleep ___Recreation ___Daily routine

Are there any activities/movements that are difficult to perform?

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

Patient Signature: ______________________________ Date: ______________