VEHICLE ACCIDENT INFORMATION

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PATIENT INFORMATION

Date ____________________

Patient Name ____________________

Date of Accident ____________________ Time of Accident ____________________

Please describe the accident in your own words ____________________

.____________________

.____________________

.____________________

Were you the: ☐ Driver ☐ Front Passenger ☐ Pedestrian ☐ Rear Passenger

How many people were in the accident vehicle?________

ACCIDENT SITE

Road/Street Name:____________________

City/State:____________________

Nearest intersection with Rd/St:____________________

Driving Conditions: __Dry, __ Wet, __ Icy, _______ Other

Which direction were you headed? ____________________

Speed you were travelling:____________________

VEHICLE

Make and model of vehicle you were in:

____

Were you wearing a seat belt? __ Yes __ No

If yes, what type? __ Lap __ Shoulder

Was the vehicle equipped with airbags? __ Yes __ No

If yes, did they initiate properly? __ Yes __ No

Did you have a head rest? __ Yes __ No

If yes, what was the position of the headrest?

__ Low __ Mid-position __ High

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 to the left __ Looking to the right

__ Looking up __ Looking down

__ Looking straight ahead

Were you: ___ Surprised by impact ___ Braced for impact

Were both hands on the wheel? __ Yes __ No

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

Was your foot on the brake? __ Yes __ No

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

OTHER VEHICLE

(If applicable)

Make and model of other vehicle:____________________

Which direction was the other vehicle headed?________

Speed other vehicle was travelling?____________________

POLICE

Did the police come to the accident site? __ Yes __ No

Were there any witness? __ 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? ___ No ___Yes 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 accident ___ Next Day ___2 days or more after the accident

How did you get to the hospital? ___ Ambulance ___ Private

Name of hospital:_______________________________ Name of Doctor:_______________________________

Diagnosis:____

____

Treatment received ____

Xrays taken: Yes __ No __ If so, where? ____

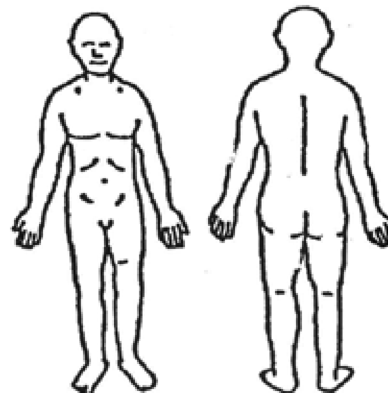
SYMPTOMS/INJURIES

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 indicate:

__ Arm/shoulder pain __ Feet/toe numbness __ Neck pain
__ Back pain __ Hand/finger numbness __ Neck stiff
__ Back stiffness __ Headaches __ Shortness of breath
__ Chest pain __ Irritability __ Sleep difficulty
__ Dizziness __ Jaw problems __ Stomach upset
__ Ear buzzing __ Leg pain __ Vision blurred
__ Ear ringing __ Memory Loss __ Tension
__ Fatigue __ Nausea



Is the condition getting progressively worse? ___ Yes ___ No ___ Unknown

Mark an X on the diagram 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 __ Dull __ Throbbing __ Numbness
__ Aching __ Shooting __ Burning __ Tingling
__ Cramps __ Stiffness __ Swelling __ Other__________

How often do you have this pain? ____________________ Is it constant, or does it come and go?_________________

Does it interfere with your: ___ Work ___ Sleep ___ Daily routine ___ Recreation?

Activities or movements that are painful to perform: __ Sitting __ Standing __ Walking __ Bending __ Lying down

I certify that the above information is correct to the best of my knowledge. I authorize benefits to be paid to the doctor, and the release of my medical records required by the Insurance Co. or lawyers to expedite payment of claims submitted. I understand that I am financially responsible for any services not covered by the Ins. Co., and agree to pay any outstanding balance in a timely manner.

Patient signature:____ Date:__________________

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