

VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Date _____

Patient Name _____

Date of Accident _____ Time of Accident _____ ☐ a.m.

☐ p.m.

Please describe the accident in your own words: _____

Were you the:
☐ Driver
☐ Rear Passenger

☐ Front Passenger
☐ Pedestrian

How many people were
in the accident vehicle? _____

ACCIDENT SITE

Road/Street Name _____

City/State _____

Nearest intersection with road/street _____

Driving conditions ☐ Dry ☐ Wet ☐ Icy ☐ Other _____

Which direction were you headed? _____

Speed you were 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 ☐ Other _____

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

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 other vehicle headed? _____

Speed other vehicle was traveling _____

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

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 ☒ check:

- | | | |
|--|---|--|
| <input type="checkbox"/> Arm/shoulder pain | <input type="checkbox"/> Feet/toe numbness | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Hand/finger numbness | <input type="checkbox"/> Neck stiff |
| <input type="checkbox"/> Back stiffness | <input type="checkbox"/> Headaches | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Irritability | <input type="checkbox"/> Sleep difficulty |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Jaw problems | <input type="checkbox"/> Stomach upset |
| <input type="checkbox"/> Ear buzzing | <input type="checkbox"/> Leg pain | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Ear ringing | <input type="checkbox"/> Memory loss | <input type="checkbox"/> Vision blurred |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Nausea | |

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture 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) _____

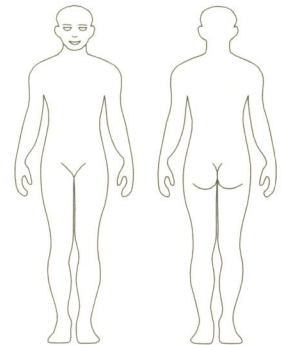
Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness
☐ Aching ☐ Shooting ☐ Burning ☐ Tingling
☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other _____

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

Movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking
☐ Bending ☐ Lying Down



To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient