VEHICLE ACCIDENT INFORMATION

Name: _____ Date: _____

Date of Accident: _____ Time: _____

Please describe the accident in your own words: _____

_____

_____

_____

_____

You were the: □ Driver □ Rear Passenger How many people were

□ Front Passenger □ Pedestrian in the accident vehicle? _____

VEHICLE

Make and model of the vehicle you were in: _____

Were you wearing seatbelt? □ Yes □ No □ Lap □ Shoulder

Was the vehicle equipped with airbags? □ Yes □ No Did it/they inflate properly? □ Yes □ No

Did your seat have a headrest? □ Yes □ No What was the position of the headrest? □ Low □ Mid □ High

Make and model of the other vehicle: _____

POLICE

Was a police report filed? □ Yes □ No

Was a traffic citation issue? □ Yes □ No To Whom? _____

IMPACT

Did any part of your body strike anything in the vehicle? □ Yes □ No Please explain: _____

_____

At the time of impact, were you:

□ Looking straight ahead □ Looking up
□ Looking to the left □ Looking down
□ Looking to the right

Were both hands on the steering wheel? □ Yes □ No If no, which hand was on the steering wheel? □ R □ L

You were: □ At a complete stop □ Moving

You were: □ Surprised by the impact □ Braced for impact

PATIENT'S CONDITION AND TREATMENT

Were you unconscious immediately after the accident? □ Yes □ No If yes, for how long? _____

Please describe how you felt immediately after the accident: _____

_____

Did you go to the hospital? □ Yes □ No

When did you go? □ Immediately after the accident □ The next day □ 2 or more days after the accident

How did you get to the hospital? □ Ambulance □ Private transportation X-Rays taken? _____

How did you feel the day after the accident? _____

_____

SYMPTOMS/ INJURIES

Have you been able to work since? □ Yes □ No How many workdays have you missed? _____

If you have had any of the following symptoms since your injury, please check:

□ Arm/ shoulder pain	□ Ear Ringing	□ Jaw Pain	□ Neck Pain
□ Back pain	□ Fatigue	□ Leg Pain	□ Shortness of breath
□ Chest Pain	□ Feet/ Toe Numbness	□ Memory Problem	□ Sleeping Problem
□ Dizziness	□ Hand/ Finger numbness	□ Nausea	□ Vision problem

Others: _____

Is the condition getting worse?□ Yes □ No □ Unknown

Mark an **X** on the picture where you have pain, numbness, or tingling.

Rate the severity of your pain on a scale of 1 (least pain) to 10 (severe pain) _____

Type of pain:□ Aching □ Dull □ Swelling
□ Burning □ Sharp □ Throbbing
□ Cramping □ Shooting □ Tingling/ Numbness
Others: _____

How often do you get this pain? _____

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

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

Patient Signature_____ Date_____