VEHICLE ACCIDENT INFORMATION

1 Patient Information

DATE _____

FIRST NAME _____ LAST NAME_____ MI _____

DATE OF ACCIDENT _____ TIME OF ACCIDENT _____☐ A.M. ☐ P.M.

PLEASE DESCRIBE THE ACCIDENT IN YOUR OWN WORDS: _____
_____
_____
_____

WERE YOU THE : ☐ DRIVER ☐ FRONT PASSENGER ☐ REAR PASSENGER ☐ PEDESTRIAN

HOW MANY PEOPLE WERE IN THE ACCIDENT VEHICLE? _____

IN CASE OF EMERGENCY WHO CAN WE CONTACT? _____ PHONE:_____

2 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?_____

3 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 THE IMPACT FROM: ☐ FRONT ☐ REAR ☐ LEFT ☐ RIGHT ☐ OTHER

AT THE TIME OF IMPACT WERE YOU: ☐ LOOKING STRAIGHT ☐ 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

WHAT IS THE ESTIMATED COST OF DAMAGE TO THE VEHICLE YOU WERE IN? $_____

4 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 ☐ MID POSITION ☐ HIGH

5 Other Vehicle

MAKE & MODEL OF OTHER CAR _____

WHICH DIRECTION WAS OTHER VEHICLE HEADED?
_____

SPEED OTHER VEHICLE WAS TRAVELING? _____

6 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?
_____

7 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 _____
_____

Was treatment received? ☐ none ☐ placed in a cervical Collar ☐ x-rayed ☐ given stitches

☐ given instructions for home care ☐ instructed to call your doctor ☐ referred to this office
☐ bandaged ☐ Other _____

List any medication Given: _____

Other Doctors seen as a result of this accident ☐ Yes ☐ No What Date: _____
Doctors Name and Phone Number: _____

8 Symptoms Injuries

have you been able to work since the 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 boxes below:

☐ 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	☐ tension
☐ ear ringing	☐ memory loss	☐ blurred vision
☐ fatigue	☐ nausea	☐ reduced tolerance to alcohol

is this condition getting progressively worse? ☐ yes ☐ no ☐ unknown

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

did you lose consciousness (blacked out) upon impact ☐ yes ☐ no if yes, for how long_____

what bruises did you sustain during accident?_____

did you sustain any bruises from the seat belt? ☐ yes ☐ no
what bleeding cuts did you sustain during this accident>_____

Signature _____ date _____