VEHICLE ACCIDENT INFORMATION

PRINT

1 Patient Information

Date Of Appointment

First Name _____ Last Name_____ Middle Initial

Date of accident _____ Time of accident _____ ☐ AM ☐ PM How many people in the accident vehicle? ____

Please describe the accident in your own words:

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

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

2 Accident Site

Street name _____

City _____ State _____

Nearest intersection _____

Driving conditions: ☐ Dry ☐ Wet ☐ Icy ☐ Other

Which direction were you headed? _____

What 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

At the time of impact, you were looking:
☐ Straight ☐ Down ☐ Up ☐ To the left ☐ To the right

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

Estimated cost of damage to your vehicle? $ _____

4 Vehicle

Make and model of vehicle you were in:

Were you wearing a seatbelt? ☐ Yes ☐ No
if yes, what type? ☐ Lap ☐ Lap/Shoulder

Was vehicle equipped with airbags? ☐ Yes ☐ No
if yes, did they inflate? ☐ 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 of other vehicle _____

Model of other vehicle _____

Direction the other vehicle traveling. _____

Approximate rate of speed of the other vehicle?

☐ Low ☐ Medium ☐ High

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 ☐ MRI/CT

☐ 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 Date: _____

Doctors Name: _____ 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 If yes, where? _____

What bleeding cuts did you sustain? _____

Signature _____ **Name** _____ **date** _____

PATIENT INFORMATION

Patient's Name_____ Preferred Name_____

Address_____

City_____ State_____ Zip_____

Phone #_____ Cell #_____ Work # _____

Email Address: _____ Birthday_____ SSN#_____ Age _____

☐Single ☐Married ☐Divorced ☐Widowed ☐Separated Name of Spouse_____

Height _____ Weight_____ ☐ Male ☐ Female

Occupation_____

Employer_____ Phone Number _____

Employer Address _____

How were you referred to our office? _____

YOUR AUTO INSURANCE INFORMATION

Insurance Name_____

Insurance Phone #: _____ Fax #: _____

Address_____ City_____

State_____ Zip_____

Policy #: _____ Date of Injury: _____

Adjuster: _____ Claim #: _____

OTHER PARTIES AUTO INSURANCE INFORMATION

Insurance Name_____

Insurance Phone #: _____ Fax #: _____

Address_____ City_____

State_____ Zip_____

Policy #: _____ Date of Injury_____

Adjuster: _____ Claim #: _____

Patient's signature_____ Name _____