

VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Patient Name _____ Date _____
Date of Accident _____ Time of Accident _____ a.m.
 p.m.

Please describe the accident in your own words: _____

Were you the: Driver Front Passenger How many people were
 Rear Passenger Pedestrian 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? _____

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 _____

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

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) _____

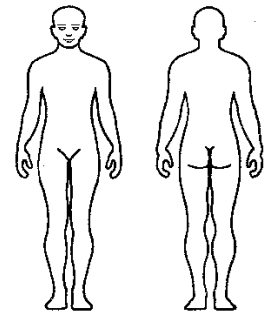
Type of pain: Sharp Dull Throbbing Numbness
 Aching Shooting Burning Tingling
 Cramps Stiffness Swelling Other _____

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

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.

Patient Signature _____ Date _____