

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 ☐ Front Passenger ☐ Rear 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? _____

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:

- ☐ Arm/shoulder pain
- ☐ Back pain
- ☐ Back stiffness
- ☐ Chest pain
- ☐ Dizziness
- ☐ Ear buzzing
- ☐ Ear ringing
- ☐ Fatigue

- ☐ Feet/toe numbness
- ☐ Hand/finger numbness
- ☐ Headaches
- ☐ Irritability
- ☐ Jaw problems
- ☐ Leg pain
- ☐ Memory loss
- ☐ Nausea

- ☐ Neck pain
- ☐ Neck stiff
- ☐ Shortness of breath
- ☐ Sleep difficulty
- ☐ Stomach upset
- ☐ Tension
- ☐ Vision blurred

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) _____

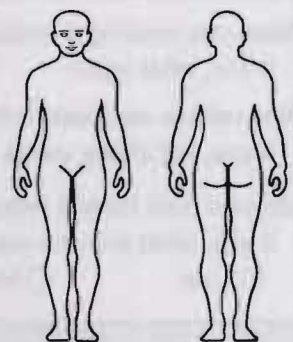
Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness
☐ Aching ☐ Shooting ☐ Burning ☐ Tingling
☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other _____

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 _____