VEHICLE ACCIDENT 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 vehicle? _____

Please draw a diagram of how the accident happened:

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:

_____

What is the approximate damage to your car? _____

Were you wearing a seatbelt? _____

If yes, what type? ☐ Lap ☐Shoulder

Was vehicle equipped with airbags? _____

If yes, did they inflate properly? _____

Did your seat have a headrest? _____

If yes, what was the position of the headrest?

☐Low ☐Mid-position ☐High

IMPACT

Did your car impact another vehicle? _____

Did your car impact a structure? _____

If yes, explain _____

_____

Did any part of your body strike anything in the vehicle? If yes, explain _____

_____

Was impact from: ☐ Front ☐ Rear ☐ Right ☐Left ☐ Other

At the time of impact were you looking:

☐ Straight ahead ☐ To the right

☐ To the left ☐ Down ☐ up

Were both hands on the steering wheel? _____

If no, which hand was on the wheel? _____

Was your foot on the brake? _____

If yes, which foot was on the brake? _____

Were you: ☐Surprised by impact ☐Braced for impact

OTHER VEHICLE

Make and model of other vehicle

_____

Which direction was other vehicle headed?

_____

Speed other vehicle was traveling _____

POLICE

Did the police come to the accident site? _____

Were there any witnesses? _____

Was a traffic violation issued? _____

If yes, to whom? _____

-OVER-

PATIENT CONDITION

Were you unconscious immediately after the accident? _____ If yes, for how long? _____
Could you move all parts of your body? _____ If no, what parts and why? _____
Were you able to get out of the car and walk unaided? _____ If no, why not? _____
What bleeding cuts did you get from this accident? _____
What bruises did you get from this accident? _____
Please describe how you felt immediately after the accident: _____

_____

TREATMENT

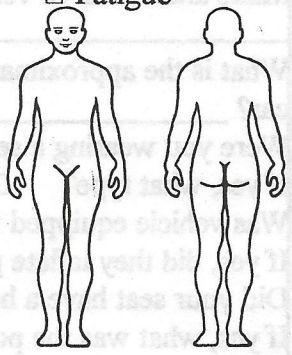
Did you go the the hospital? _____
When did you go? ☐ Immediately after accident ☐ Next day ☐ 2 days of more after the accident
How did you get to the hospital? ☐ Ambulance ☐ Private transportation
Name of hospital _____ Name of doctor _____
Diagnosis _____ Treatment received _____
X-rays taken _____
Did you seek medical help immediately/soon after the accident other than at a hospital? _____
If yes, what is the doctors name? _____

SYMPTOMS/INJURIES

Have you been able to work since this injury? _____ How many work days have you missed? _____
What is your occupation? _____ What is your employers name? _____
Prior to the injury were you able to work on an equal basis with others your age? _____
If you have had any of the following symptoms since your injury, please check:

☐ Arm/Shoulder pain	☐ Feet/toe numbness	☐ Neck pain	☐ Neck stiffness
☐ Back Pain	☐ Hand/finger numbness	☐ Shortness of breath	☐ Chest pain
☐ Irritability	☐ Sleep difficulty	☐ Dizziness	☐ Jaw problems
☐ Stomach upset	☐ Ear buzzing	☐ Leg pain	☐ Tension
☐ Ear ringing	☐ Memory loss	☐ Vision blurred	☐ Fatigue
☐ 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) _____
How often do you have this pain? _____ Is it constant? _____
Does it interfere with your: ☐ work ☐Sleep ☐ Daily routine ☐Recreation
Activities or movements that ☐ Sitting ☐ Standing ☐ Walking
are painful to perform: ☐ Bending ☐ Lying Down

PRIOR to this accident, have you EVER had symptoms similar to what you're experiencing now? _____
If yes, please describe in detail: _____
Briefly list past falls, injuries, accidents and operations: _____

_____

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

Patient Signature _____ Date _____
Parent or guardian (if under 18) _____ Date _____