VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Date_____

Patient Name_____

Patient Insurance Company _____ Claim Number _____

Date of Accident_____ Time 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:

_____

Where 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

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

Where you: □Surprised by impact □Braced for impact

OTHER VEHICLE

(if applicable)

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? □Yes □No

Were there any witnesses? □Yes □No

Was a police report filled? □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 the 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 days have you missed? _____

If you have had any of the following symptoms since your injury, please check the box

□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 bussing	□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 (sever 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

Movements that are painful to perform: □Sitting □Standing □Walking
□Bending □Laying down

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____
Signature of patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Parent, Guardian or Personal Representative Relationship to the Patient