

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 Rear Passenger Front 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 & 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 Mid-position High

Other Vehicle

Make & model of other vehicle _____

Which direction was the 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 To the left To the right Down 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? 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 the 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 the Doctor _____

Diagnosis: _____

Treatment received: _____

X-rays taken: _____

Symptoms / Injuries

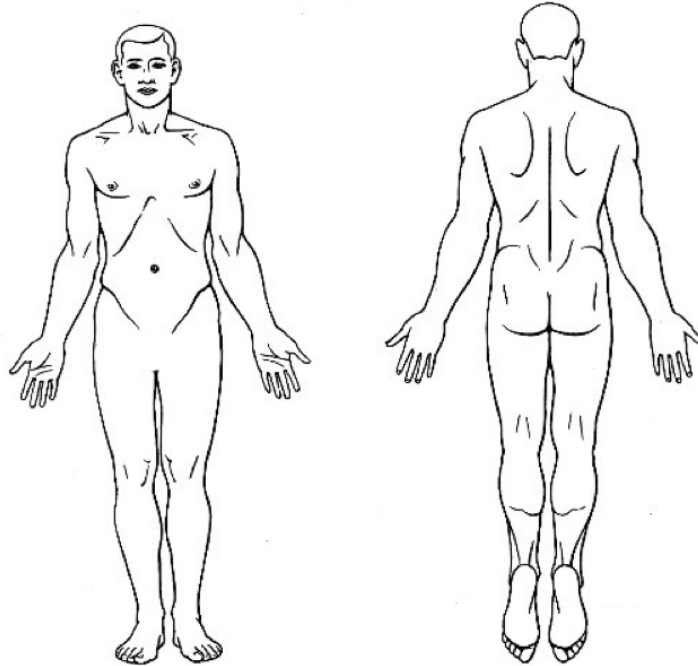
Have you been able to work since this injury? Yes No How many work days have you missed? _____
Prior to the injury were you able to work on an equal basis with others your age? Yes No
If you have had any of the following symptoms since your injury, please check the box:

- | | | |
|--|---|--|
| <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

Symptoms / Injuries (continued)

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:

- | | | |
|------------------------------------|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Dull | <input type="checkbox"/> Throbbing |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Aching | <input type="checkbox"/> Shooting |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Tingling | <input type="checkbox"/> Cramps |
| <input type="checkbox"/> Stiffness | <input type="checkbox"/> Swelling | <input type="checkbox"/> 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.

Print Name

Signature

Date