VEHICILE ACCIDENT INFORMATION

PATIENT INFORMATION

Date_____

Patient Name_____

Date of Accident _____ Time of Accident_____ AM____ PM____

Please describe the accident in your own words:_____

_____

_____

Were you the: ___ Driver ___Front Passanger ___Rear Passanger ___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 head have a headrest? ___ Yes ___ No

If yes, what was the position of the headrest?

___ Low ___ Midposition ___ High

OTHER

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, please 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 left

___ Looking Up

___ Looking to the right

___ Looking Down

Were both hands on the steering wheel?

___ Yes ___ No

Was your foot on the brake?

___ Yes ___ No

If yes, which foot was on the brake?

___ Right ___ Left

Were you: ___Braced for impact ___Surprised by impact

POLICE

Did the Police come to the accident site? ___ Yes ___ No

Were there any witnesses? ___ Yes ___ No

Was there a police report? ___ 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? ___ Immediatley after accident ___ Next Day ___ 2 days or more after accident

How did you get to the hospital? ___ Ambulance ___ Private Transportation

Name of Hospital _____

Diagnosis _____

_____

SYMPTOMS AND INJURIES

Have you been able to work since this injury? ___ Yes ___ No

How many days have you missed? _____

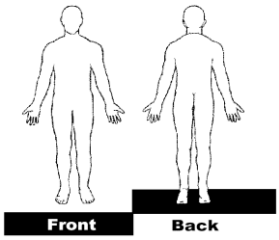
Prior to the injury were you able to work on an equal basis with others your age? ___ Yes ___ No

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

___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 buzzing	___ Leg Pain	___ Tension
___ Ear ringing	___ Memory problems	___ 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) _____

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 ___Lying 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 of health.

_____ _____

Signature of Patient, Guardian or Personal Representative Date

_____ _____

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