

# 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 travelling \_\_\_\_\_

## 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?  Left  Right

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

## 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

Make and model of other vehicle:

\_\_\_\_\_

Which direction was the other vehicle headed?

\_\_\_\_\_

Speed other vehicle was travelling:

\_\_\_\_\_

## 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 after the incident? Yes No If yes, 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 \_\_\_\_\_

Treatment recieved \_\_\_\_\_

\_\_\_\_\_

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 injurt were you able to work in 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

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 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 of 1 (least pain) to 10 (severe pain) \_\_\_\_\_

Type of pain: Sharp Dull Throbbing Numbness

Aching Shooting Burning Tingling

Cramps Stiffness Swelling Other \_\_\_\_\_

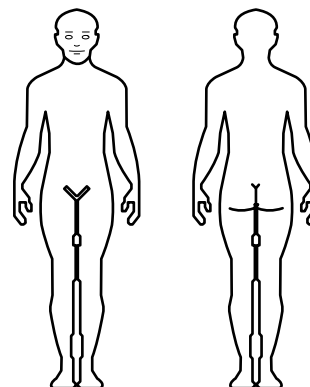
How often do you have this pain? \_\_\_\_\_

Is it constant, or does it come and go? \_\_\_\_\_

Does it interfere with your Work Sleep Daily routine Recreation

Activites 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 knowlege

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_