VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Today's Date _____ Patient Name _____ DOB _____

DATE OF ACCIDENT _____ Time _____am / pm

Please describe the accident in your own words _____

_____

_____

Were you the: ☐Driver ☐Front Passenger ☐Rear Passenger ☐Pedestrian ☐Bicycle ☐Wheelchair

List your injury(s) _____ Did you lose consciousness? ____Y ____N

Since your injury, are your symptoms: ☐Same ☐Getting better ☐Getting worse

Have you ever had any complaints in the involved area before accident? ☐Y ☐N Explain: _____

Are your work activities restricted as a result of this accident? ☐Y ☐N Explain: _____

Have you missed work due to this injury? ☐Y ☐N Dates off work: _____

ACCIDENT SITE

Road/Street Name _____

City/State _____

Nearest intersection to road/street _____

VEHICLE

Make & Model of vehicle you were in _____

Were you wearing a seatbelt? ☐Y ☐N

If yes, what type? ____Lap & Shoulder ____Lap ____Shoulder

Did airbags inflate ? ☐Y ☐N

IMPACT

Did your car impact: ☐Another vehicle ☐A Structure

If yes, please explain_____

Did your body strike anything in the vehicle? ☐Y ☐N

If So, What _____

Was impact from ___Front ___Rear ___Right ___Left

Were you braced for the impact? ☐Y ☐N

At the time of impact were you thrown:

____ Forward ____Backward ____ Right ____Left

POLICE

Did the police come to the scene of accident? ____Y ____N

Was a police report filed? ____Y ____N

If yes, Police Dept? _____

Were there any witnesses? ___Y ____N

Was a traffic violation issued? ____Y ____N

If yes, to whom? _____

PATIENT CONDITION

Check symptoms you have noticed since the accident:

☐Headache ☐Head seems too heavy ☐Pins and Needles

☐Sleeping problems ☐Numbness in Fingers or Toes

☐Shortness of Breath ☐Dizziness ☐ Memory Loss

☐Ears Ring ☐Diarrhea ☐Constipation ☐Fever

☐Chest Pain ☐Fatigue ☐Fainting ☐Loss of Balance

YOUR VEHICLE

Insurance Company _____

Policy No. _____

Insured Name _____

Claim#: _____

Adjustor: _____

OTHER VEHICLE

Insurance Company_____

Policy No. _____

Insured Name_____

Claim#: _____

Adjuster: _____

Have you retained an attorney? ☐Y ☐N If So, Name and Phone #: _____

TREATMENT

Did you go to the hospital? ____Y ____N If yes, Name of Hospital _____

When did you go to hospital? ☐Immediately after accident ☐Next Day ☐2 or more days after accident

How did you get to the hospital? ☐Ambulance ☐Drove Yourself ☐Family/Friend

X-rays taken? ☐N ☐Y Of What _____ MRI Done? ☐N ☐Y Of What _____

CT Scan Done? ☐Y ☐N If yes, of what _____ Lab Work Done? ☐Y ☐N

Diagnosis _____

Medication Prescribed? ☐N ☐Y If so, Name: _____

Was any other doctor consulted after your accident? ☐Y ☐N Doctor's Name: _____