

# 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 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 seat have a headrest? ☐ Yes ☐ No  
If yes, what was the position of the headrest?  
☐ Low ☐ Midposition ☐ High

## OTHER VEHICLE

(if applicable)

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, 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

Were you: ☐ Surprised by impact ☐ Braced for impact

## 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 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 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 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:

☐ Arm/shoulder pain

☐ Back pain

☐ Back stiffness

☐ Chest pain

☐ Dizziness

☐ Ear buzzing

☐ Ear ringing

☐ Fatigue

☐ Feet/toe numbness

☐ Hand/finger numbness

☐ Headaches

☐ Irritability

☐ Jaw problems

☐ Leg pain

☐ Memory loss

☐ Nausea

☐ Neck pain

☐ Neck stiff

☐ Shortness of breath

☐ Sleep difficulty

☐ Stomach upset

☐ Tension

☐ Vision blurred

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) \_\_\_\_\_

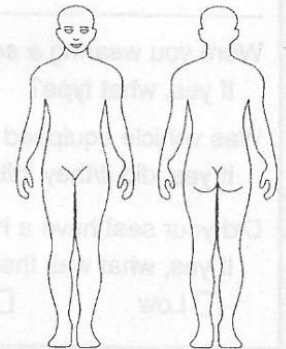
Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness  
☐ Aching ☐ Shooting ☐ Burning ☐ Tingling  
☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other \_\_\_\_\_

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 in health.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Relationship to Patient