

# 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

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## 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

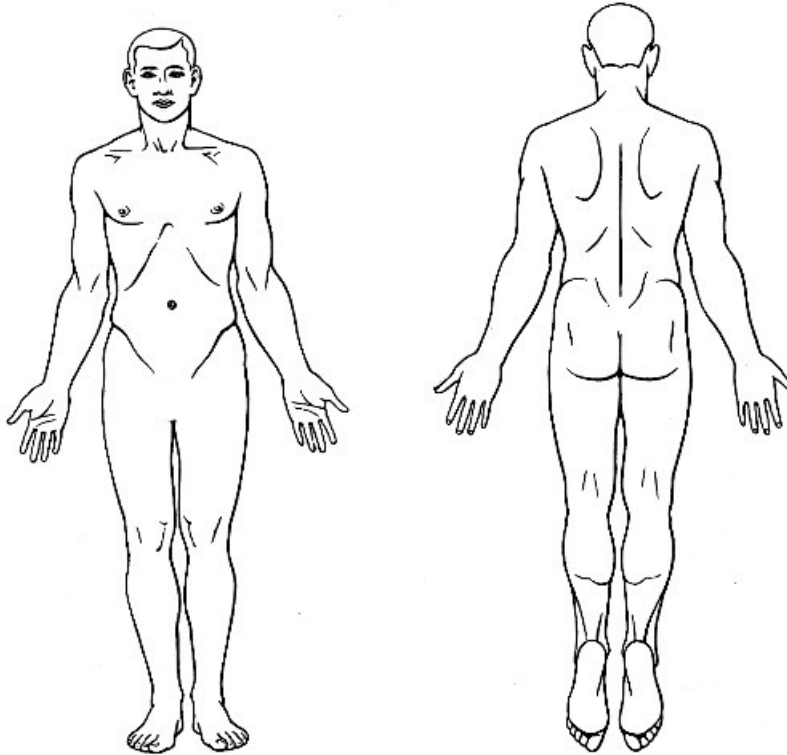
If you have had any of the following symptoms since your injury, please check the box:

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

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