

Vehicle Accident Form

Patient Information

Patient Name: _____ Date: _____

Date Of Accident: _____ Time of Accident: _____ A.M. P.M.

Please describe the accident in your own words: _____

Where you the: Driver Front Passenger Rear Passenger Pedestrian
How many people where 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: _____

Where you wearing a seat belt? Y/N

If yes, what type? Lap Shoulder

Was vehicle equipped with air bags? Y/N

If yes, did they inflate properly? Y/N

Did your seat have a headrest? Y/N

If yes, what position was it in?

Low Mid-Position High

Other Vehicle (if applicable)

Make and model of other vehicle: _____

Which direction was the other vehicle headed? _____

Speed of other vehicle? _____

Impact

Did your car impact another vehicle? Y/N

Did your car impact a structure? Y/N

If yes, explain: _____

Did any part of your body strike anything in the vehicle? Y/N Explain: _____

Was the impact from: Front Rear Left Right

At the time of impact were you looking:

Straight ahead To the right

To the left Down

Up

Where both hands on the wheel? Y/N

If no, which had was on the wheel?

Left Right

Was your foot on the brake? Y/N

If yes, which foot?: Left Right

Where you:

Surprised by impact

Braced for impact

Police

Did the police come to the accident? Y/N

Are there any witnesses? Y/N

Was a police report filed? Y/N

Was a traffic violation issued? Y/N

If yes, to whom? _____

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Patient Condition

Where you unconscious immediately after the accident? Y/N If yes, how long? _____

Please describe how you felt immediately after the accident? _____

Treatment

Did you go to the hospital? Y/N

When did you go? Immediately after accident Next day 2 or more days after

How did you get to the hospital? Ambulance Private Transportation

Name of Hospital: _____

Diagnosis: _____

Treatment: _____

X-rays: _____

Symptoms/Injuries

Have you been able to work since the injury? Y/N How many days have you missed? _____

Prior to the injury were you able to work on an equal basis with others your age? Y/N

Circle any of the following symptoms you have had since your injury:

Arm/Shoulder Pain

Irritability

Vision Blurred

Back Pain

Jaw Problems

Tension

Back Stiffness

Leg Pain

Stomach Upset

Chest Pain

Memory Loss

Sleep Difficulty

Dizziness

Nausea

Headaches

Ear Buzzing

Neck Pain

Hand/Finger Numbness

Ear Ringing

Neck Stiffness

Feet/Toe Numbness

Fatigue

Shortness of Breath

Is this condition getting progressively worse? Yes No Unknown

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: _____ Constant or 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 of any changes in health.

Signature: _____ Date: _____

Printed Name: _____

Patient Number: _____