AUTO ACCIDENT INFORMATION

PATIENT INFORMATION
Date _____
Name _____ DOB _____ Phone _____
Address _____ City _____ State _____ Zip _____

ACCIDENT SITE
Date of Accident _____ Time of Accident _____ AM PM
Driving Conditions: ☐ Dry ☐ Wet ☐ Icy ☐ Other _____
Street/Intersection _____ City _____ State _____
What direction were you headed? _____ What speed were you traveling? _____
Were you the ☐ Driver ☐ Front Passenger ☐ Right Rear Passenger ☐ Left Rear Passenger ☐ Pedestrian?
Please describe the accident in your own words: _____
_____
_____

VEHICLE
Make and model of the vehicle you were in: _____
Were you wearing seatbelts? Y / N If yes, what type? ☐ lap ☐ shoulder
Was vehicle equipped with airbags? Y / N If yes, did they inflate properly? Y / N
Did your seat have a headrest? Y / N If yes, what was its position? ☐ low ☐ mid-position ☐ high

IMPACT
Did your car impact a structure? Y / N If yes, explain: _____
Did your car impact another vehicle? Y / N Estimated speed of your vehicle at impact? _____MPH
Did another vehicle impact your vehicle? Y / N Estimated speed of other vehicle at impact? _____MPH
What direction was the other vehicle headed? _____
Was impact from: ☐ front ☐ rear ☐ left ☐ right ☐ other _____?
Were you: ☐ surprised at impact ☐ braced for impact?
At the time of impact were you: ☐ looking straight ahead ☐ looking up ☐ looking down ☐ looking to the left/right (circle)
Did any part of your body strike anything in the vehicle? Y / N If yes, explain: _____

INSURANCE INFORMATION

YOUR VEHICLE	OTHER VEHICLE
Driver _____	Driver _____
Insured _____	Insured _____
Address _____	Address _____
Phone _____	Phone _____
Auto Insurance Co _____	Auto Insurance Co _____
Address _____	Address _____
Phone _____	Phone _____
Policy # _____	Policy # _____
Claim # _____	Claim # _____

Has an insurance adjuster or company representative regarding this claim contacted you? Y / N

Do you have an attorney who has advised you in this case? Y / N Name _____
Address _____ City _____ State _____ Phone _____

PATIENT CONDITION

Were 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

If yes, when did you go? ☐ Immediately after the accident ☐ Next day ☐ 2 + days after

Name of Hospital _____ Name of Doctor _____

X-rays taken? Y / N Diagnosis _____

Treatment received _____

SYMPTOMS/INJURIES

Have you lost any time from work because of this accident? Y / N

If yes, give days of disability:

Totally disabled from _____ to _____ Partially disabled from _____ to _____

Have you returned to work since the accident? Y / N

If you have had any of the following symptoms since your injury, please √ check.

☐ Headache	☐ Irritability	☐ Eyes sensitive to light
☐ Neck pain/stiffness	☐ Nervousness	☐ Blurred vision
☐ Back pain/stiffness	☐ Depression	☐ Ear ringing
☐ Pins/needles in arms	☐ Cold hands/feet	☐ Ear buzzing
☐ Pins/needles in legs	☐ Cold sweats	☐ Loss of smell
☐ Numbness in fingers	☐ Fever	☐ Loss of taste
☐ Numbness in toes	☐ Sleeping problems	☐ Loss of memory
☐ Tension	☐ Fatigue	☐ Loss of balance
☐ Head feels heavy	☐ Constipation	☐ Dizziness
☐ Chest pain	☐ Diarrhea	☐ Nausea
☐ Shortness of breath	☐ Stomach upset	☐ Other _____

Primary complaint: _____

Is this condition getting: ☐ better ☐ worse ☐ staying about the same?

Have you had anything like this before? Y / N

Rate the severity of your pain on a scale from 1 to 10 _____

(1- 3 mild pain, 4-6 moderate pain, 7-10 severe pain with 10 being the worst pain imaginable)

Type of pain: _____

How often do you have this pain? _____

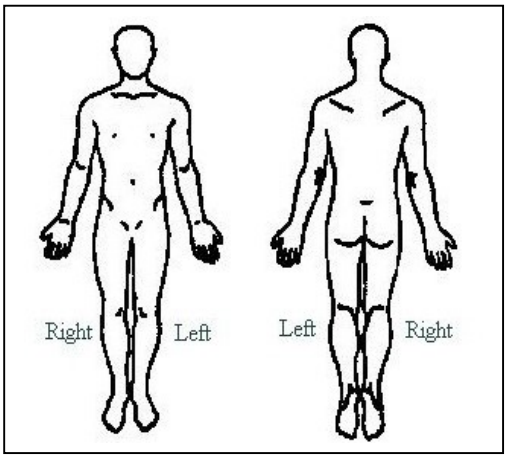
Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine

☐ Recreation ☐ Other _____

Activities painful to perform: ☐ Sitting ☐ Standing ☐ Walking

☐ Bending ☐ Lying Down



Doctor's Notes:

_____

_____

_____

_____

_____

I certify that the above information is correct to the best of my knowledge.

Patient Signature _____ Date _____