Auto Accident Information

Patient Name: _____ Date: _____

Date and time of accident: _____ ☐ a.m. ☐ p.m.

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger

Make and model of the vehicle you were occupying?

_____

If a traffic violation was issued, to whom was it issued?

_____

Number of people in accident vehicle? _____

Did the police come to the accident site? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Were you wearing a seat belt? ☐ Yes ☐ No

Was this vehicle equipped with airbags? ☐ Yes ☐ No

If yes, did it/ they inflate? ☐ Yes ☐ No

In relation to the base of your skull, where was the headrest?

☐ Above ☐ Below ☐ At base of skull

What did your vehicle impact? ☐ Another vehicle ☐ Other

If other, explain: _____

Did any part of your body strike anything in the vehicle? ☐ Yes ☐ No

If yes, please describe:

_____

Make and model of the other vehicle(s) involved?

_____

Name of the location/ street on which you were traveling?

_____

In which direction were you headed? ☐ N ☐ S ☐ E ☐ W

What was the approx. speed of your vehicle? _____

Did the impact to your vehicle come from the:

☐ Front ☐ Rear ☐ Right Side ☐ Left Side ☐ Other

During impact, were you facing: ☐ Right ☐ Left ☐ Forward

Were you: ☐ aware ☐ surprised by the impact?

If accident vehicle made impact with another vehicle:

Direction other vehicle was headed? ☐ N ☐ S ☐ E ☐ W

Approximate Speed of the other vehicle? _____

In your words, please describe the accident:

_____

_____

After Injury:

Did accident render you unconscious? ☐ Yes ☐ No

If yes, for how long? _____

Please describe how you felt immediately after the accident:

_____

Have you gone to a hospital or seen any other Doctor? ☐ Yes ☐ No

When did you go? ☐ Just after accident ☐ The next day ☐ 2 days plus

How did you get there? ☐ Ambulance ☐ Private transportation

Name of hospital and/ or attending doctor:

_____

Was he/she a: ☐ D.C. ☐ M.D. ☐ D.O. ☐ D.D.S.

Describe any treatment you received:

_____

Were X-Rays taken? ☐ Yes ☐ No

Was medication prescribed? ☐ Yes ☐ No

Have you been able to work since this injury? ☐ Yes ☐ No

Are your work activities restricted as a result of this injury? ☐ Yes ☐ No

Indicate the symptoms that are a result of this accident:

☐ Dizziness ☐ Difficulty Sleeping ☐ Jaw problems ☐ Nausea

☐ Memory loss ☐ Irritability ☐ Arms/ shoulder pain ☐ Back pain

☐ Headache(s) ☐ Fatigue ☐ Numb hands/fingers ☐ Lower back pain

☐ Blurred vision ☐ Tension ☐ Back stiffness ☐ Buzzing in ear

☐ Neck pain ☐ Chest pain ☐ Leg pain ☐ Ears ringing

☐ Neck stiff ☐ Shortness of breath ☐ Numb feet/ toes ☐ Stomach upset

☐ Other (please describe):

_____

Is your condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable	Painful
Lying on back……	☐	☐	☐
Lying on side……	☐	☐	☐
Lying on stomach…….	☐	☐	☐
Sitting…….	☐	☐	☐
Standing……..……	☐	☐	☐
Stretching……	☐	☐	☐
Lovemaking……..	☐	☐	☐
Walking……	☐	☐	☐
Running…….	☐	☐	☐
Sports……..	☐	☐	☐
Working……	☐	☐	☐
Lifting……	☐	☐	☐
Bending……...	☐	☐	☐
Kneeling……...	☐	☐	☐
Pulling……..	☐	☐	☐
Reaching…….	☐	☐	☐

Have you retained an attorney: ☐ Yes ☐ No

If yes, whom? _____

His/ Her phone #:_____

Recovery

How many hours are in your normal workday? _____

Please indicate on your daily job duties and any activities, which you are occasionally asked to perform.

☐ Standing	☐ Driving	☐ Operating equipment
☐ Sitting	☐ Twisting	☐ Work with arms above head
☐ Walking	☐ Crawling	☐ Lifting
☐ Bending	☐ Typing	☐ Stooping

☐ Other:

_____

_____

What positions can you work in with minimum physical effort and for how long?

_____

_____

_____

Prior to the injury were you capable of working on an equal basis with others your age? ☐ Yes ☐ No ☐ N/A

Do you work with others who can help you with any heavy lifting? ☐ Yes ☐ No ☐ N/A

While in recovery, is there any light duty work you could request? ☐ Yes ☐ No ☐ N/A

Signature _____ Date____/_____/_____

☐ Adult patient ☐ Parent or Guardian ☐ Spouse