Auto Accident Patient Form

Your Contact Information

Full Name: _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Cell Phone: _____ ☐ OK to text me **Work Phone:** _____

Email: _____

Best way to reach me: ☐ Cell ☐ Text ☐ Work ☐ Email

Date of Birth: _____ **Sex:** ☐ Male ☐ Female

Social Security Number: _____ - _____ - _____

Work Information

Job title/What you do: _____

Employer: _____

Work address: _____

Supervisor's name: _____

Have you missed work because of this accident? ☐ Yes ☐ No

☐ Full days missed: _____
☐ Partial days missed: _____
☐ I haven't been able to work at all since the accident

About Your Accident

When did the accident happen? Date: _____ Time: _____

Where did it happen? (street names/intersection)_____

Draw a diagram of the accident as you remember it:

Details About the Crash

Your Vehicle:

Were you moving? ☐ Yes ☐ No
Were you braking? ☐ Yes ☐ No
How fast were you going? _____ mph (your best guess)
Year/make/model: _____

The Other Vehicle:

How fast were they going? _____ mph (guess if not sure) ☐ Don't know
Year/make/model: _____

Who was driving the car? _____

Who owns the car? _____

Where were you sitting? _____

Accident Conditions

Weather/visibility:

☐ Clear ☐ Rainy ☐ Icy ☐ Dark ☐ Other: _____

Which part of your car was hit?_____

What type of crash was it?

☐ Head-on collision ☐ Rear-end ☐ Side impact (T-bone) ☐ Other: _____

Safety Equipment

Did you see the accident coming? ☐ Yes ☐ No

Did you brace yourself before impact? ☐ Yes ☐ No

Were you wearing a seatbelt? ☐ Yes ☐ No

Were you wearing a shoulder strap? ☐ Yes ☐ No

Does your car have headrests? ☐ Yes ☐ No
If yes, where was the headrest compared to your head?

☐ Below my head ☐ Even with the top of my head ☐ Even with my neck

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Your Position During Impact

Where was your head?

☐ Looking straight ahead ☐ Turned left or right ☐ Looking back

Where was your body?

☐ Sitting straight ☐ Twisted left or right ☐ Other: _____

Were you wearing glasses or a hat? ☐ Yes ☐ No

Did any part of your body hit something inside the car? ☐ Yes ☐ No

If yes, describe what hit what: _____

Right After the Accident

Right after the accident, were you:

☐ Knocked out ☐ In shock ☐ Confused/dazed ☐ Shaken up ☐ Other: _____

Could you move all parts of your body? ☐ Yes ☐ No

If no, what couldn't you move? _____

Could you get out of the car and walk on your own? ☐ Yes ☐ No

If no, why not? _____

Did you get any cuts or bruises? ☐ Yes ☐ No

If yes, where? _____

How You Felt

Right after the accident:

Later that same day:

The next day:

Symptoms since the Accident

Check all that apply:

Head & Neck:

☐ Headache ☐ Neck pain/stiffness ☐ Dizziness ☐ Sensitive to light ☐ Pain behind eyes

Back & Body:

☐ Mid back pain ☐ Low back pain ☐ Chest pain

Arms & Legs:

☐ Numbness in fingers ☐ Numbness in toes ☐ Cold hands ☐ Cold feet

Sleep & Energy:

☐ Trouble sleeping ☐ Fatigue/very tired ☐ Shortness of breath

Mental/Emotional:

☐ Memory problems ☐ Irritability ☐ Depression ☐ Nervousness/anxiety ☐ Tension

Other:

☐ Ringing/buzzing in ears ☐ Loss of balance ☐ Loss of smell ☐ Loss of taste

☐ Sweating (cold sweats) ☐ Stomach issues (diarrhea/constipation)

☐ Other: _____

Before the Accident

Did you have any pain or symptoms RIGHT BEFORE the accident? ☐ Yes ☐ No

If yes, what? _____

Have you EVER had similar symptoms before this accident? ☐ Yes ☐ No

If yes, explain (include past injuries, falls, surgeries, etc.):

Medical Care after the Accident

Did you see a doctor right away? ☐ Yes ☐ No
Date you saw a doctor_____

Were you examined? ☐ Yes ☐ No

Were x-rays taken? ☐ Yes ☐ No

Any findings:_____

Did you receive treatment? ☐ Yes ☐ No

What treatment?_____

Did the treatment help? _____

Your Health History

Past medical issues related to this accident:

☐ None ☐ Previous car accident ☐ Previous work accident ☐ Surgery/hospital stay

☐ Illness ☐ Other_____

Personal Information

Current medications:

Current illnesses/diseases:

Current Symptoms

Check any symptoms you have RIGHT NOW:

Stomach/Digestion:

- ☐ Poor appetite
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation

Bladder/Urinary:

- ☐ Trouble urinating
- ☐ Painful urination

Brain/Nervous System:

- ☐ Numbness/Tingling
- ☐ Dizziness
- ☐ Headaches
- ☐ Forgetfulness
- ☐ Confusion

Heart/Lungs:

- ☐ Pain over heart
- ☐ Hard to breathe
- ☐ High blood pressure
- ☐ Rib pain

Eyes, Ears, Nose, Throat:

- ☐ Vision problems
- ☐ Ear pain
- ☐ Ringing in ears
- ☐ Hearing loss

How Pain Affects Your Daily Life

Pick ONE answer in each section that best describes you:

Pain Level

- ☐ Pain comes and goes and is very mild
- ☐ Pain is mild all the time
- ☐ Pain comes and goes and is moderate
- ☐ Pain is moderate all the time
- ☐ Pain comes and goes and is severe
- ☐ Pain is severe all the time

Getting Dressed/Showering

- ☐ I can do everything normally without extra pain
- ☐ I can do everything normally but it hurts more
- ☐ It's painful and I have to go slow
- ☐ I need some help but can do most things
- ☐ I need help every day
- ☐ I can't get dressed and stay in bed

Lifting Things

- ☐ I can lift heavy things without pain
- ☐ I can lift heavy things but it hurts
- ☐ I can't lift heavy things off the floor
- ☐ I can lift things if they're on a table (not the floor)
- ☐ I can only lift very light things
- ☐ I can't lift or carry anything

Walking

- ☐ Pain doesn't stop me from walking
- ☐ I can't walk more than 1 mile
- ☐ I can't walk more than 1/2 mile
- ☐ I can't walk more than 1/4 mile (2-3 blocks)
- ☐ I can only walk with a cane or crutches
- ☐ I'm in bed most of the time

Sitting

- ☐ I can sit in any chair as long as I want
- ☐ I can only sit in my favorite chair as long as I want
- ☐ I can't sit for more than 1 hour
- ☐ I can't sit for more than 30 minutes
- ☐ I can't sit for more than 10 minutes
- ☐ I can't sit at all

Standing

- ☐ I can stand as long as I want without pain
- ☐ I can stand as long as I want but it hurts
- ☐ I can't stand for more than 1 hour
- ☐ I can't stand for more than 30 minutes
- ☐ I can't stand for more than 10 minutes
- ☐ I can't stand at all

Sleeping

- ☐ Pain doesn't stop me from sleeping well
- ☐ I can only sleep well if I take medicine
- ☐ Even with medicine, I sleep less than 6 hours
- ☐ Even with medicine, I sleep less than 4 hours
- ☐ Even with medicine, I sleep less than 2 hours
- ☐ Pain stops me from sleeping at all

Social Life

- ☐ Normal with no pain
- ☐ Normal but increases pain
- ☐ Can't do energetic activities (like dancing)
- ☐ Don't go out as often
- ☐ Limited to my home only
- ☐ No social life because of pain

Traveling

- ☐ I can travel anywhere without pain
- ☐ I can travel anywhere but it hurts
- ☐ Pain is bad but I can handle trips over 2 hours
- ☐ I can only do trips less than 1 hour
- ☐ I can only do short trips (under 30 minutes)
- ☐ I can only travel to the doctor or hospital

How Your Pain is Changing

- ☐ Pain is getting better fast
- ☐ Pain goes up and down but overall getting better
- ☐ Pain seems to be improving slowly
- ☐ Pain is staying the same
- ☐ Pain is getting worse gradually
- ☐ Pain is getting worse fast

Where Does It Hurt?

Check all areas where you have pain:

Spine:

☐ Low back ☐ Mid back ☐ Neck ☐ Pelvis

Arms:

☐ Shoulder (R/L) ☐ Upper arm (R/L) ☐ Elbow (R/L)
☐ Forearm (R/L) ☐ Wrist (R/L) ☐ Hand (R/L)

Legs:

☐ Hip (R/L) ☐ Thigh (R/L) ☐ Knee (R/L) ☐ Lower leg (R/L)
☐ Ankle (R/L) ☐ Foot (R/L)

Other: _____

Pain Scale

Rate your pain RIGHT NOW from 0-10:

0 = No pain | 5 = Moderate pain | 10 = Worst pain imaginable

My current pain level: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Patient Signature: _____ **Date:** _____