Patient Accident Report

Name: ________________________________ Date of Accident: ____________ Time: ________

Please answer the following questions as fully as possible:

1. Your position in the car (please circle) Driver Front Passenger Rear Passenger
2. What type of vehicle were you in? ____
3. Number of persons in the vehicle: ____
4. Where did the accident occur? (street) ____

   Direction you were traveling? ____
5. Was another vehicle involved? Yes No Make and model: ____________________________

   If yes, who was at fault? ____

   Please provide a copy of the police accident report, insurance information for the party at fault (including claim number), and your insurance card.
6. State exactly which part of your vehicle was struck: ______________________________________
7. Were you aware of the oncoming accident? Yes No
8. At the moment of impact, was your vehicle (please circle) Stopped Moving Turning R or L
9. Were you wearing a seatbelt? Yes No Type: Lap Shoulder Air bag? Yes No
10. Is your vehicle equipped with head restraints? Yes No Were they: Up Down
11. Upon impact, which way were you thrown? ____
12. Did you strike the: Steering wheel Dash Door Windshield

    Other: ____
13. Were you able to get out of your vehicle and walk? Yes No
14. Have you been in a vehicle accident before? Yes No If yes, please list date(s) and injuries:

    ____
15. Have you been off work due to this accident? Yes No

    If yes, please list dates: ____
16. Have you had a previous similar disability? Yes No

    If yes, please list dates: ____

17. Considering the above information, describe your accident:
____
____

18. When did your symptoms first appear? (please circle) Immediately/right after Hours later

Days later Weeks later Months later Years later

19. Locations of pain: ____

20. When does it hurt? ____

21. Radiation (did pain move or "shoot")? Yes No

22. Type of pain (please circle): Sharp Stabbing Dull ache Burning

Throbbing Numbing Tightness Gripping

Other: ____

23. Could you move all body parts normally? Yes No

Please describe: ____
____

24. Did you experience any of the following symptoms? (please circle all that apply)

Joint pain Stiffness Sleep difficulty Nervousness Depression
Dizziness Nausea Vomiting Numbness Headaches
Bleeding Back pain Tingling Swelling Arm or leg sensations
Loss of consciousness Blinding explosion feeling
Other: ____

25. Considering the above, describe your immediate symptoms after the accident in your own words:
____
____

26. Were you taken to the hospital? Yes No If yes, which one?____________________________

27. Were x-rays taken? Yes No Date: _______ Which body parts? ____________________________

28. Considering the above, what are your present symptoms? ____________________________________
____

29. Does anything relieve the symptoms? ____

30. Are your symptoms getting better or worse? ____

31. Have you seen any other doctor? Yes No Name of doctor(s): ___________________________

32. Have you had any therapy? Yes No Where? ___________________________________

Frequency: ___________________________ Type: ____

Response to therapy: ____

Signed: ____________________________________ Date: ______________________________20____