ACCIDENT INFORMATION

Date of Accident: _____/_____ / _____ Time of Accident: _____ a.m. / p.m.

Your Vehicle: Year _____ Other Vehicle: Year _____to Your Vehicle: $_____Other Vehicle Damage: $ _____

Describe Accident: _____

_____

Were you: _____Driver_____Passenger_____Pedestrian_____ Other _____

What kind of vehicle were you in?_____What was the other vehicle?

_____How many people were in your vehicle?

_____Were any of them injured? ☐ Yes ☐ No

If you were a passenger, were you in the: ☐ Front Seat ☐ Right Rear Seat ☐ Left Rear Seat

If you were a pedestrian/other, where were you? Were you wearing a seatbelt? ☐ Yes ☐ No;

If yes, what type of seatbelt? ☐ 3-point ☐ Lap Belt

Did the vehicle you were in have head rests? ☐ Yes ☐ No

Where did your accident occur (address or description of location)?_____

Was your vehicle: ☐ Stopped ☐ Moving at approx. speed of_____mph ☐ Turning Left ☐ Turning Right

Did your vehicle strike the other vehicle? ☐ Yes ☐ No, If no, were you struck by the other vehicle from: ☐ Behind ☐ Front

☐ Left Side ☐ Right Side Approximate speed of the other vehicle?_____mph

Did the airbags deploy on impact? Driver ☐ Yes ☐ No; Passenger ☐ Yes ☐ No ☐ Forward ☐ Backward\

Did your vehicle go into a spin or roll? ☐ Yes ☐ No

Were you: ☐ Shoved Forward ☐ Whipped Backward ☐ Shoved Sideways? Please Explain_____

_____

Did any part of your body hit any part of the interior of the vehicle? ☐ Yes ☐ No; If yes, Please explain_____

_____

Were you knocked unconscious ☐ Yes ☐ No

If yes, for how long?_____

Were the police notified? ☐ Yes ☐ No Was a police report filed? ☐ Yes ☐ No

In your own words, please describe the accident:_____

_____

Please list the body parts injured because of your accident:_____

_____

At the moment just prior to impact, were you aware there was going to be a collision?_____

☐ Yes ☐ No ☐ Did you brace with your hands for impact? ☐ Yes ☐ No

Did you brace with your feet for impact? ☐ Yes ☐ No

Body position at the moment of impact: ☐ Upright Leaning Forward ☐ Turning to the Rear ☐ Other.

At the moment of impact, were you looking: ☐ Forward ☐ Right ☐ Left ☐ Up ☐ Down

Position of your hands

Left: _____ Right: _____

Position of your feet (on the brake, on the floor, etc.):

Left: _____ Right: _____

Please describe how you felt: During the accident

_____

Immediately following the accident

_____

Later that day

_____

The next day

_____

ACCIDENT INFORMATION

Check symptoms you have noticed since the accident:

Headache	Dizziness	Depression	Fatigue	Light Sensitive Eyes
Buzzing in Ears	Diarrhea	Neck Pain	Head feels heavy	Memory Loss
Feet Cold	Neck Stiff	Pins and Needles in Arms	Ears Ringing	Hands Cold
Fainting	Sleeping Problems	Back Pain	Face Flushed	Loss of Balance
Constipation	Tension	Pins and Needles in Legs	Nervousness	Numbness in Fingers
Loss of Smell	Fever	Irritability	Numbness in Toes	Loss of Taste
Chest Pain	Cold Sweats	Shortness of Breath	Stomach Upset	Other:_____

Symptoms (Not related to the accident)

Check All that apply:

Neck Pain	Chronic Sinusitis	Mid Back Pain	Low Back Pain	Headaches
Arm Numbness	Shoulder Pain	Hip Pain Migraines	Hand Numbness	Heart Disease
Leg Pain	Vertigo	Arm Pain	Asthma	Leg Numbness
Dizziness	Throat Issues	Gastric Reflux	Numbness in Feet	Nausea
Thyroid Problems	Ulcers	Knee Pain	TMJ	Chronic Fatigue
Chest Pain	Kidney Problems	Ear Infections	Fibromyalgia	Chronic Illness
IBS	Anxiety	Lupus	Liver Disease	Bladder Problems

Top 3 Health Concerns	Severity 1=MILD / 10 = UNBEARABLE	Date of Onset	Did the problem begin with an injury?	Are symptoms constant or intermittent?
1.	10			
2.	10			
3.	10			

Do you have any congenital (from birth) factors which relate to this problem? Yes No; If yes, please describe: _____

Do you have any previous illnesses which relate to this case? Yes No; If yes, please describe: _____

Weather Conditions were they: Sunny Raining Snowing Foggy

The Road was: Dry Wet Icy Time of Day: Dawn Day Dusk Night

Immediately Following The Accident: (Mark a ▌on each that applies to the accident)

Ambulance / Paramedics were called	I was treated at the scene
I was transported to Hospital by Ambulance	I went to Hospital in my own
I was diagnosed at the Hospital	I was treated at the Hospital
Medication was prescribed	Follow-up was recommended

OTHER DOCTORS SEEN:

Orthopedist	Neurologist	Psychiatrist	Physiatrist	Chiropractor
Acupuncturist	General Practitioner	Physical Therapist	Massage Therapist	Other_____

Have you ever been involved in an accident before? Yes No; If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received.

Have you lost time from work as a result of this accident? Yes No; If yes, please complete this question.

a. Last Day Worked:_____ b. Type of Employment: _____c. Present Salary: _____ d. Are you being compensated for time lost from work? Yes No; If yes, please state type of compensation you are receiving: _____

Do you notice any activity restrictions as a result of this injury? Yes No; If yes, please describe, in detail: _____

ACCIDENT INFORMATION

HISTORY OF TREATMENT

When did you first seek treatment for this accident?_____

Initially, did you go to a Hospital/Emergency Room? ☐ Yes ☐ No; If no, please continue with Name of Doctor/Facility below. If yes, name of Hospital/ER_____City_____

Were you admitted to the Hospital? ☐ Yes ☐ No; If yes, for how long? _____Name of doctors at the Hospital/ER who treated you_____

Describe the type of treatment/diagnostic testing you received _____

_____

What did the doctors say was wrong with you? _____

_____

Were you told you would need more treatment? ☐ Yes ☐ No; If yes, were you referred somewhere else? ☐ Yes ☐ No;

If yes, where were you referred and for what?_____

Did the doctors take you off work? ☐ Yes ☐ No; Did the doctor(s) restrict or modify your work? ☐ Yes ☐ No; If yes, please explain_____

Name of Doctor/Facility #1_____City_____

DateTreatmentStarted_____DateTreatmentEnded_____

Number of Visits_____Type of Doctor (degree or specialty)_____

Describetreatmentand/ortests_____

What did this doctor say was wrong with you? _____

Did this doctor take you off work? ☐ Yes ☐ No; Did this doctor restrict or modify your work? ☐ Yes ☐ No;

If yes, please explain (include dates)

Did this doctor say you would need more treatment? ☐ Yes ☐ No; If yes, please explain Did this doctor refer you anywhere else?

☐ Yes ☐ No; If yes, please explain_____

_____

Are you still treating with this doctor? ☐ Yes ☐ No; If yes, how often?

What was the result/outcome of the treatment?_____

_____