VEHICLE ACCIDENT INFORMATION

PATIENT IN	FORMATION	
	Date	
Patient Name		
Date of Accident	Time of Accident a.m.	
	□ p.m.	
Please describe the accident in your own words:		
ay D 2 days or more after sedjoens. D 2 thate transportation.	Did ven de to the heserial/Y 10ks 1 1 No. When did you go? I Immadisjery efter accinant I Next of tow aid you get to the hospital? I Ambulance	
	nt Passenger How many people were in the accident vehicle?	
ACCIDENT SITE	IMPACT	
Road/Street Name		
To be the state of	Did your car impact another vehicle? ☐ Yes ☐ No	
City/State Nearest intersection with road/street	Did your car impact a structure? ☐ Yes ☐ No	
1 Care 25 (4) 1	If yes, explain	
Driving conditions ☐ Dry ☐ Wet ☐ Icy ☐ Other	Prior to the entury were you able to work on an edual basts with	
Which direction were you headed?	Did any part of your body strike anything in the vehicle?	
Speed you were traveling?	☐ Yes ☐ No If yes, explain	
the and the population of the control of the contro	Was impact from :	
	☐ Front ☐ Rear ☐ Left ☐ Right ☐ Other	
VEHICLE	a had Ell V Entering V Eller bill	
Make and model of vehicle you were in:	At the time of impact were you: ☐ Looking straight ahead ☐ Looking to the right	
Word you wooding a pooling to	☐ Looking to the left ☐ Looking down	
Were you wearing a seatbelt? ☐ Yes ☐ No If yes, what type? ☐ Lap ☐ Shoulder	Looking up	
Was vehicle equipped with airbags? ☐ Yes ☐ No	Were both hands on the steering wheel? ☐ Yes ☐ No	
If yes, did it/they inflate properly? Yes No	If no, which hand was on the wheel? ☐ Right ☐ Left	
Did your seat have a headrest? ☐ Yes ☐ No	Was your foot on the brake? ☐ Yes ☐ No	
If yes, what was the position of the headrest?	If yes, which foot was on the brake? ☐ Right ☐ Left	
☐ Low ☐ Midposition ☐ High	Were you: ☐ Surprised by impact ☐ Braced for impact	
OTHER VEHICLE (if applicable)	POLICE	
2 Oown	Did the police come to the accident site? ☐ Yes ☐ No	
Make and model of other vehicle	Were there any witnesses? ☐ Yes ☐ No	
Which direction was other vehicle headed?	Was a police report filed? ☐ Yes ☐ No	
Speed other vehicle was traveling	Was a traffic violation issued? ☐ Yes ☐ No If yes, to whom?	

PATIENT CONDITION		
Were you unconscious immediately after the accident? Yes No If yes, for how long? Please describe how you felt immediately after the accident:		
coldant	A to sted	
TREATMENT		
Did you go to the hospital?		
Treatment received		
X-rays taken		
SYMPTOMS/INJURIES		
Have you been able to work since this injury?	on edinic	
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) Type of pain: Sharp Dull Throbbing Numbness Aching Shooting Burning Other How often do you have this pain?	X b	
Is it constant or does it come and go?		
Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation		
Movements that are painful to perform: Sitting Standing Walking Bending Uying Down		
To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever change in health. Signature of Patient, Parent, Guardian or Personal Representative Date	have a	

Relationship to Patient

Please print name of Patient, Parent, Guardian or Personal Representative