VEHICLE ACCIDENT INFOLMATION

PATIENT INFORMATION	
	Date
Patient Name	
Date of Accident	
TOS. N	□ p.m.
Please describe the accident in your own words:	
I Were volume:	ont Passenger How many people were destrian in the accident vehicle?
ACCIDENT SITE	IMPACT
Road/Street Name	Did your car impact another vehicle? ☐ Yes ☐ No Did your car impact a structure? ☐ Yes ☐ No
Nearest intersection with road/street	If yes, explain
Driving conditions ☐ Dry ☐ Wet ☐ Icy ☐ Other	
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
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VEHICLE	☐ Front ☐ Rear ☐ Left ☐ Right ☐ Other
Make and model of vehicle you were in:	At the time of impact were you: Looking straight ahead Looking to the right Looking to the left Looking down
Were you wearing a seatbelt?	☐ Looking up
If yes, what type? ☐ Lap ☐ Shoulder Was vehicle equipped with airbags? ☐ Yes ☐ No If yes, did it/they inflate properly? ☐ Yes ☐ No	Were both hands on the steering wheel? ☐ Yes ☐ No If no, which hand was on the wheel? ☐ Right ☐ Left
Did your seat have a headrest? ☐ Yes ☐ No If yes, what was the position of the headrest?	Was your foot on the brake? ☐ Yes ☐ No If yes, which foot was on the brake? ☐ Right ☐ Left
☐ Low ☐ Midposition ☐ High	Were you: ☐ Surprised by impact ☐ Braced for impact
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OTHER VEHICLE (If applicable)	POLICE
Make and model of other vehicle	Did the police come to the accident site? Yes No Were there any witnesses? Yes No Was a police report filed? Yes No Was a traffic violation issued? Yes No If yes, to whom?

PATIENT CONDITION	
Were you unconscious immediately after the accident?	
TREATMENT	
Did you go to the hospital?	
Treatment received	
X-rays taken	
SYMPTOMS/INJURIES	
Have you been able to work since this injury?	
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 Tingling Cramps Stiffness Swelling Other How often do you have this pain? Is it constant or does it come and go? Does it interfere with your: Work Sleep Daily Routine Recreation	
Activities or movements that are painful to perform: Sitting Standing Walking Bending Lying Down	
I certify that the above information is correct to the best of my knowledge.	
Patient Signature Date	