VEHICLE ACCIDENT REPORT

A.) DATE OF ACCIDENT ____/_____/____ TIME OF ACCIDENT ____:_____ (AM/PM)

B.) DESCRIPTION OF ACCIDENT / INJURY:

____Automobile Accident ____Workman Compensation Accident / Injury

____Slip/Fall Accident ____Pedestrian Accident

____Other Accident / Injury _____

1. What was the cause of your accident / injury? _____

_____

_____

_____

_____

2. Describe in your own words what happened:_____

_____

_____

_____

_____

3. Were you: ____driver ____ passenger (front) ____ passenger (back) ___ pedestrian

4. Were you wearing seatbelts? ___ yes ___no

5. Your approximate speed: _____ mph other vehicle approximate speed: _____ mph

6. Did you strike your: (circle as many as apply)

A.) **Head**	**against the:**	dashboard	windshield	steering wheel	rt door	lft door	seat frame	unknown object
B.) **Shoulder (L/R)**	**against the:**	dashboard	windshield	steering wheel	rt door	lft door	seat frame	unknown object
C.) **Arm (L/R)**	**against the:**	dashboard	windshield	steering wheel	rt door	lft door	seat frame	unknown object
D.) **Elbow (L/R)**	**against the:**	dashboard	windshield	steering wheel	rt door	lft door	seat frame	unknown object
E.) **Wrist (L/R)**	**against the:**	dashboard	windshield	steering wheel	rt door	lft door	seat frame	unknown object
F.) **Hip (L/R)**	**against the:**	dashboard	windshield	steering wheel	rt door	lft door	seat frame	unknown object
G.) **Knee (L/R)**	**against the:**	dashboard	windshield	steering wheel	rt door	lft door	seat frame	unknown object
H.) **Ankle (L/R)**	**against the:**	dashboard	windshield	steering wheel	rt door	lft door	seat frame	unknown object

C.) IMMEDIATELY AFTER ACCIDENT / INJURY

1. Did you lose consciousness? ____ yes _____ no _____ don't know
2. How did you feel? ____confused ____dazed ____dizzy ____nervous ____weak
3. Where did you immediately develop pain?

____head	R / L shoulders	R / L buttocks
____neck	R / L arms	R / L hips
____upper/ mid back	R / L elbows	R / L thighs
____lower back	R / L forearms	R / L knees
____pelvis	R / L wrists	R / L legs
____chest / rib cage	R / L hands	R / L ankles
____abdomen	R / L feet	other_____

4. If there were lacerations (cuts), where are/were located_____
5. If there were any bruises, where are/were they located_____
6. Describe any other significant injury?_____

_____

_____

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7. Emergency Care at accident/injury site:

Did you receive care? ____ yes ____no
What type of emergency care did you receive?_____
Destination immediately after accident/injury:
Where did you go? ____hospital ____home ____school ____work ____other
By whom were you driven? ____self ___ambulance ___friend ___family ___other

D.) HOSPITAL VISIT AFTER ACCIDENT/INJURY:

1. When did you go to the hospital? ____immediately ____later that day ____next day ___days later
2. Hospital name_____
3. Were you admitted? ____ yes ____no date discharged?_____
4. If x-rays were taken, of what body parts? _____
5. What treatment was administered at the hospital? ____oral medication ___sutures ___injection ___bandages ___ice packs ___hot packs ____cast ____brace ____surgery ___collar ____topical antiseptics ____other
6. Instructions given when discharged from hospital:
   Were you told to see? ___general practitioner ___physical therapist ___general surgeon ____chiropractor ___orthopedist ___neurologist ____internist ____plastic surgeon
7. Were mediations prescribed? ___pain ____anti-inflammatory ___antibiotic ____ other

E.) FOLLOWING THE ACCIDENT/INJURY:

1. How much after did additional symptoms develop?
   ___ immediately ____ hours ____that evening ____ next morning ____ days ____weeks ____ month other _____
2. What additional symptoms developed? ____pain ____stiffness ___numbness ____tingling
3. What body parts did this happen in? _____
4. Since your accident/injury have you suffered from? ____blurred vision ____chest pain ____nausea ____double vision ____difficulty breathing ____vomiting ____reduced visions ____palpitations ____frequent urination ____diarrhea ____impaired hearing ____ringing in ears ____painful urination ____constipation
5. Have you experienced any of the following? ____anxiety ____convulsions ____restlessness ____depression ____dizziness ____insomnia ____mood swings ____headaches ____light sensitivity ____nervousness ____fainting ____reduced appetite ____poor memory ____weakness ____loss of balance ____tension ____fatigue ____other
6. Have you missed work due to this accident/injury? ____ yes ____no
7. Did you self treat your problems? ___ice ____heat ____bed rest ____over the counter meds

F.) INSURANCE / ATTORNEY INFORMATION:

1. Have you contacted an insurance adjuster or representative regarding this claim? ___ yes ___no
   Company_____
   Adjuster:_____
   Claim #_____
2. Have you engaged services of an attorney? ___ yes ___no
   Attorney_____
   Address _____
   Phone _____
3. Have you filed an accident/ injury report? ____ yes ____no
4. Have you file for insurance benefits? ____ yes ____no

Patient's signature_____ Date: _____

Patients name (print) _____