VEHICLE ACCIDENT REPORT

A.) DATE OF ACCIDENT _____ TIME OF ACCIDENT _____

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 wordswhat 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:

___Head	_____	against the:	__dashboard__windshield __steering wheel __rt door __lft door __seat frame __unknown object
___Shoulder	_____	against the:	__dashboard__windshield __steering wheel __rt door __lft door __seat frame __unknown object
___Arm	_____	against the:	__dashboard__windshield __steering wheel __rt door __lft door __seat frame __unknown object
___Elbow	_____	against the:	__dashboard__windshield __steering wheel __rt door __lft door __seat frame __unknown object
___Wrist	_____	against the:	__dashboard__windshield __steering wheel __rt door __lft door __seat frame __unknown object
___Hip	_____	against the:	__dashboard__windshield __steering wheel __rt door __lft door __seat frame __unknown object
___Knee	_____	against the:	__dashboard__windshield __steering wheel __rt door __lft door __seat frame __unknown object
___Ankle	_____	against the:	__dashboard__windshield __steering wheel __rt door __lft door __seat frame __unknown object

C.) IMMEDIATELY AFTE R 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	_____ shoulders	_____buttocks
_____neck	_____ arms	_____hips
_____upper/ mid back	_____elbows	_____thighs
_____lower back	_____forearms	_____knees
_____pelvis	_____wrists	_____legs
_____chest / rib cage	_____hands	_____ankles
_____abdomen	_____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 hospita
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.) FOLL OWING THE ACCIDENT/INJURY:

1. How much after did additional symptoms develop?
____ immediately _____ hours _____that evening _____ next mornin _____ 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/injuryhave 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 _____constipatior
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 ____
Company_____
State in which policy is in effect _____
Adjuster:_____
Claim #_____
Claims address _____
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) _____