



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 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:

<input type="checkbox"/> Head	against the:	<input type="checkbox"/> dashboard	<input type="checkbox"/> windshield	<input type="checkbox"/> steering wheel	<input type="checkbox"/> rt door	<input type="checkbox"/> lft door	<input type="checkbox"/> seat frame	<input type="checkbox"/> unknown object
<input type="checkbox"/> Shoulder	against the:	<input type="checkbox"/> dashboard	<input type="checkbox"/> windshield	<input type="checkbox"/> steering wheel	<input type="checkbox"/> rt door	<input type="checkbox"/> lft door	<input type="checkbox"/> seat frame	<input type="checkbox"/> unknown object
<input type="checkbox"/> Arm	against the:	<input type="checkbox"/> dashboard	<input type="checkbox"/> windshield	<input type="checkbox"/> steering wheel	<input type="checkbox"/> rt door	<input type="checkbox"/> lft door	<input type="checkbox"/> seat frame	<input type="checkbox"/> unknown object
<input type="checkbox"/> Elbow	against the:	<input type="checkbox"/> dashboard	<input type="checkbox"/> windshield	<input type="checkbox"/> steering wheel	<input type="checkbox"/> rt door	<input type="checkbox"/> lft door	<input type="checkbox"/> seat frame	<input type="checkbox"/> unknown object
<input type="checkbox"/> Wrist	against the:	<input type="checkbox"/> dashboard	<input type="checkbox"/> windshield	<input type="checkbox"/> steering wheel	<input type="checkbox"/> rt door	<input type="checkbox"/> lft door	<input type="checkbox"/> seat frame	<input type="checkbox"/> unknown object
<input type="checkbox"/> Hip	against the:	<input type="checkbox"/> dashboard	<input type="checkbox"/> windshield	<input type="checkbox"/> steering wheel	<input type="checkbox"/> rt door	<input type="checkbox"/> lft door	<input type="checkbox"/> seat frame	<input type="checkbox"/> unknown object
<input type="checkbox"/> Knee	against the:	<input type="checkbox"/> dashboard	<input type="checkbox"/> windshield	<input type="checkbox"/> steering wheel	<input type="checkbox"/> rt door	<input type="checkbox"/> lft door	<input type="checkbox"/> seat frame	<input type="checkbox"/> unknown object
<input type="checkbox"/> Ankle	against the:	<input type="checkbox"/> dashboard	<input type="checkbox"/> windshield	<input type="checkbox"/> steering wheel	<input type="checkbox"/> rt door	<input type="checkbox"/> lft door	<input type="checkbox"/> seat frame	<input type="checkbox"/> 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?

<input type="checkbox"/> head	<input type="checkbox"/> shoulders	<input type="checkbox"/> buttocks
<input type="checkbox"/> neck	<input type="checkbox"/> arms	<input type="checkbox"/> hips
<input type="checkbox"/> upper/ mid back	<input type="checkbox"/> elbows	<input type="checkbox"/> thighs
<input type="checkbox"/> lower back	<input type="checkbox"/> forearms	<input type="checkbox"/> knees
<input type="checkbox"/> pelvis	<input type="checkbox"/> wrists	<input type="checkbox"/> legs
<input type="checkbox"/> chest / rib cage	<input type="checkbox"/> hands	<input type="checkbox"/> ankles
<input type="checkbox"/> abdomen	<input type="checkbox"/> 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:

- When did you go to the hospital? immediately later that day next day days later
- Hospital name _____
- Were you admitted? yes no date discharged? _____
- If x-rays were taken, of what body parts? _____
- What treatment was administered at the hospital oral medication sutures
 injection bandages ice packs hot packs cast brace surgery
 collar topical antiseptics other
- Instructions given when discharged from hospital
 Were you told to see? general practitioner physical therapist general surgeon
 chiropractor orthopedist neurologist internist plastic surgeon
- Were medications prescribed? pain anti-inflammatory antibiotic other

E.) FOLLOWING THE ACCIDENT/INJURY:

- How much after did additional symptoms develop?
 immediately hours that evening next morning days
 weeks month other _____
- What additional symptoms developed? pain stiffness numbness tingling
- What body parts did this happen in? _____
- Since your accident/injury have you suffered from? blurred vision chest pain
 nausea double vision difficulty breathing vomiting
 reduced vision palpitations frequent urination diarrhea
 impaired hearing ringing in ears painful urination constipation
- 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
- Have you missed work due to this accident/injury? yes no
- Did you self treat your problems? ice heat bed rest over the counter meds

F.) INSURANCE / ATTORNEY INFORMATION:

- Have you contacted an insurance adjuster or representative regarding this claim? yes no
 Company _____
 State in which policy is in effect _____
 Adjuster: _____
 Claim # _____
 Claims address _____
- Have you engaged services of an attorney? yes no
 Attorney _____
 Address _____
 Phone _____
- Have you filed an accident/ injury report? yes no
- Have you file for insurance benefits? yes no

Patient's signature _____ Date: _____

Patients name (print) _____