



# 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:

___ <b>Head</b>	<b>against the:</b>	___ dashboard	___ windshield	___ steering wheel	___ rt door	___ lft door	___ seat frame	___ unknown object
___ <b>Shoulder</b>	<b>against the:</b>	___ dashboard	___ windshield	___ steering wheel	___ rt door	___ lft door	___ seat frame	___ unknown object
___ <b>Arm</b>	<b>against the:</b>	___ dashboard	___ windshield	___ steering wheel	___ rt door	___ lft door	___ seat frame	___ unknown object
___ <b>Elbow</b>	<b>against the:</b>	___ dashboard	___ windshield	___ steering wheel	___ rt door	___ lft door	___ seat frame	___ unknown object
___ <b>Wrist</b>	<b>against the:</b>	___ dashboard	___ windshield	___ steering wheel	___ rt door	___ lft door	___ seat frame	___ unknown object
___ <b>Hip</b>	<b>against the:</b>	___ dashboard	___ windshield	___ steering wheel	___ rt door	___ lft door	___ seat frame	___ unknown object
___ <b>Knee</b>	<b>against the:</b>	___ dashboard	___ windshield	___ steering wheel	___ rt door	___ lft door	___ seat frame	___ unknown object
aaa <b>Ankle</b> "*****"	<b>against the:</b>	___ 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	___ 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 hospital:  
Were you told to see? \_\_\_ general practitioner \_\_\_ physical therapist \_\_\_ general surgeon  
\_\_\_ chiropractor \_\_\_ orthopedist \_\_\_ neurologist \_\_\_ internist \_\_\_ plastic surgeon  
7. Were medications 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 \_\_\_\_\_  
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) \_\_\_\_\_