VEHICLL ACCIDENT INFO 2 MATION

PATIENT INFORMATION			
	Date		
Patient Name			
	Time of Accident a.m.		
	□ p.m.		
Please describe the accident in your own words:			
Were you the: ☐ Rear Passenger ☐ Pe	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		
City/State	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		
	Was impact from :		
VEHICLE	At the time of impact were you:		
Make and model of vehicle you were in:	Looking straight ahead Looking to the right		
	☐ Looking to the left ☐ Looking down		
Were you wearing a seatbelt? ☐ Yes ☐ No	Looking up		
If yes, what type? ☐ Lap ☐ Shoulder	Were both hands on the steering wheel? ☐ Yes ☐ No		
Was vehicle equipped with airbags? ☐ Yes ☐ No If yes, did it/they inflate properly? ☐ Yes ☐ No	If no, which hand was on the wheel? Right Left		
Did your seat have a headrest? ☐ Yes ☐ No	Was your foot on the brake? ☐ Yes ☐ No		
If yes, what was the position of the headrest?	If yes, which foot was on the brake? ☐ Right ☐ Left		
☐ Low ☐ Midposition ☐ High	Were you: ☐ Surprised by impact ☐ Braced for impact		
OTHER VEHICLE (if applicable)	POLICE		
ika di menuntuk di banan salah sebagai mengangan segarah segarah sebaggian perbaggian perpada perjada perjada p Manan selah di banan selah sebagai menuntuk segarah segarah segarah sebaggian perbaggian perpada perjada perjad	Did the police come to the accident site? ☐ Yes ☐ No		
Make and model of other vehicle	Were there any witnesses? ☐ Yes ☐ No		
Which direction was other vehicle headed?	Was a police report filed? ☐ Yes ☐ No ☐ Was a traffic violation issued? ☐ Yes ☐ No ☐ Yes ☐ Yes ☐ Yes ☐ No ☐ Yes ☐		
Speed other vehicle was traveling	If yes, to whom?		

PATIEN	T CONDITION	
Were you unconscious immediately after the accident?		
TREATMENT		
Did you go to the hospital? Yes No When did you go? Immediately after accident How did you get to the hospital? Ambulance Name of hospital Diagnosis	☐ Private transportati Name of doctor	on
Treatment received		
X-rays taken		
· ·	OMS/INJURIES	
Have you been able to work since this injury? Yes No How many work days have you missed? Prior to the injury were you able to work on an equal basis with others your age? Yes No If you have had any of the following symptoms since your injury, please check:		
Back pain	Feet/toe numbness Hand/finger numbness Headaches rritability law problems Leg pain Memory loss	 Neck pain Neck stiff Shortness of breath Sleep difficulty Stomach upset Tension Vision blurred
Is this condition getting progressively worse?		
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)		
☐ Aching ☐ Shooting ☐ Burning [□ Numbness □ Tingling □ 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 ☐ Recreatio	n
,	☐ Standing ☐ Walking ☐ Lying Down	
To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.		
Signature of Patient, Parent, Guardian or Personal Re	epresentative	Date
Please print name of Patient, Parent, Guardian or Persona	al Representative	Relationship to Patient