VEHICLE ACCIDENT INFORMATION

PATIENT NAME: _____DATE: _____ / _____ / _____

DATE OF ACCIDENT: _____ / _____ TIME OF ACCIDENT: _____ AM _____ PM

Please describe the accident in your own words: _____

_____

_____

_____

You were the: ____ Driver ____ Front Passenger ____ Rear Passenger

ATTORNEY/INSURANCE INFORMATION

Do you have private health insurance? ___ If yes, Insurance Name: _____

Policy/ID#: _____ Phone #: _____

Do you have an attorney? ___ If yes, who: _____ Phone: _____

Address: _____ City: _____ State: ____ Zip: _____

Your auto insurance company: _____ ,Phone #: _____

Other driver's insurance company: _____ Phone#: _____

Adjuster's name: _____ Claim #: _____

ACCIDENT SITE

Street Name: _____ City: _____ State: ____

Driving condition: _____ Wet _____ Dry _____ Icy Speed you were traveling: _____ mph

VEHICLE INFORMATION

Make & Model of car you were in: _____

Make & Model of other car: _____

Was your car equipped with airbags?: _____ If yes, did they inflate? _____

Does your car have a headrest? _____ If yes, what was the position? _____ Low _____ Medium _____ High

Did your car strike another car? _____ If yes, explain:, _____

Did your car strike a structure? _____ If yes, explain: _____

Where was the impact? _____ Front _____ Left side _____ Right side _____ Rear

Were you wearing a seatbelt? _____ Both hands on the steering wheel? _____ If no, explain: _____

_____

Was your foot on the brake? _____ If yes, which foot: _____ Left _____ Right

Were you: _____ Surprised by the impact _____ Braced for the impact

Did the police come to the accident scene? ____ Were there any witnesses? ____ If yes, was that information given? _____

_____

Was a traffic ticket issued? ____ If yes, to whom? _____

Was a police report filed? If yes, do you have a copy? ____ If no, can you get a copy? ____

TREATMENT

Was it necessary for you to go to the hospital: If yes,: _____ Immediately following the accident _____ Next day _____ Two or more days after accident

Name of hospital: _____ Name of Doctor: _____

Diagnosis given, if any: _____ Treatment rendered: _____

Was any medication prescribed?: _____ If yes, what: _____

Were x_rays taken?: _____ If yes, do you have them? _____ If not, can you get them? _____

SYMPTOMS/INJURIES

If you are employed, have you missed any work since this accident? ____

If yes, what is the first day you missed? _____

How many hours a week do you work: Have you returned to work?: If yes, what date did you return to work: _____

Were you able to work your regular hours: _____ If nor, how many hours did you work a week: _____

Were you able to perform your regular work duties?: _____ If not, what were you unable to do: _____

_____

Please check any symptoms you are experiencing since this accident:

_____ Neck pain/stiff	_____ Hip pain	_____Upset stomach
_____ ArmIshoulder pain	_____ Knee pain	_____Tension
_____Headaches	_____Dizziness	_____Blurred vision
_____ Mid-back pain	_____ Fatigue	_____ Instability
_____ Low back pain/stiff	_____Nausea	_____Chest pain
_____ Leg pain	_____ Memory loss	_____Tingling in hands/fingers
_____ Feet/toes numbness	_____ Shortness of breath	_____ Ringing in ears
_____Hands numb/weak	_____ Difficulty sleeping	_____ Grinding/popping sounds in neck

Any symptom(s) not listed above: _____

GENERAL INFORMATION

If employed; does your job require any of the following: (Check all that apply) _____ Excessive lifting _____

Bending _____ Sitting _____ Standing _____ Walking Other: _____

Do you sleep on a regular mattress or a waterbed?: _____, Age of mattress or bed: _____

How many hours a night do you usually sleep? _____ What kind of pillow do you use? _____

Is this pillow: _____ soft _____ firm _____ thin _____ thick

Do you sleep with more than one pillow? _____ If yes, how many: _____

I certify that the above information is correct to the best of my knowledge. I will not hold the doctor or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

_____

Patient Signature

Reviewed by: _____

Date: _____ / _____ / _____