VEHICLE ACCIDENT INFORMATION

| PATIENT INFORMATION | |
|--|--|
| | Date |
| Patient Name | |
| Date of Accident | Time of Accident a.m. |
| Please describe the accident in your own words: | |
| Were you the: ☐ Driver ☐ Fro | ont Passenger How many people were destrian in the accident vehicle? |
| ACCIDENT SITE | IMPACT |
| Road/Street Name | Did your car impact another vehicle? |
| Were you wearing a seatbelt? | □ Looking to the left □ Looking down □ Looking up Were both hands on the steering wheel? □ Yes □ No If no, which hand was on the wheel? □ Right □ Left Was your foot on the brake? □ Yes □ No If yes, which foot was on the brake? □ Right □ Left Were you: □ Surprised by impact □ Braced for impact |
| OTHER VEHICLE | POLICE |
| (if applicable) Make and model of other vehicle Which direction was other vehicle headed? Speed other vehicle was traveling | Did the police come to the accident site? |

| PATIENT CONDITION | | |
|--|--|--|
| Were you unconscious immediately after the accident? Yes No If yes, for how long? Please describe how you felt immediately after the accident: | | |
| | | |
| TREATMENT | | |
| Did you go to the hospital? | | |
| Treatment received | | |
| X-rays taken | | |
| | | |
| SYMPTOMS/INJURIES | | |
| Have you been able to work since this injury? | | |
| 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 Recreation | | |
| Movements that are painful to perform: Sitting Standing Walking Bending 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 Representative Date | | |
| Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient | | |