VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION	
	Date
Patient Name	
Date of Accident	
Please describe the accident in your own words:	□ p.m.
all periods and the control of the c	
I Were voll the:	Front Passenger How many people were In the accident vehicle?
ACCIDENT SITE	IMPACT
Road/Street Name	Did your car impact another vehicle? ☐ Yes ☐ No
City/State	
Nearest intersection with road/street	100 Mary 100
Driving conditions ☐ Dry ☐ Wet ☐ Icy ☐ Other	EG 3 PELEO GERBE A RELEASE TO SEE A SELECTION OF SELECTIO
Which direction were you headed?	Did any and at the static anything in the vehicle?
Speed you were traveling?	Did any part of your body strike anything in the vehicle? ☐ Yes ☐ No If yes, explain Was impact from :
	☐ Front ☐ Rear ☐ Left ☐ Right ☐ Other
Make and model of vehicle you were in:	At the time of impact were you: Looking straight ahead Looking to the left Looking down
Were you wearing a seatbelt? ☐ Yes ☐ No If yes, what type? ☐ Lap ☐ Shoulde	☐ Looking up
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 If yes, what was the position of the headrest?	Was your foot on the brake? ☐ Yes ☐ No If yes, which foot was on the brake? ☐ Right ☐ Left
☐ Low ☐ Midposition ☐ High	Were you: ☐ Surprised by impact ☐ Braced for impact
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OTHER VEHICLE (If applicable)	POLICE
Make and model of other vehicle	Did the police come to the accident site? Yes No Were there any witnesses? Yes No Was a police report filed? Yes No Was a traffic violation issued? Yes No
Speed other vehicle was traveling	_ If yes, to whom?

Were you unconscious immediately after the accident?	
TREATMENT	
Did you go to the hospital?	
Treatment received	
A-rays takeri	
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 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 Representative Date	
Please print name of Patient, Parent, Guardian or Personal Representative Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient	