

## VEHICLE ACCIDENT REPORT

A.) DATE OF ACCIDENT \_\_\_/\_\_\_/\_\_\_ TIME OF ACCIDENT \_\_\_:\_\_\_ (AM/PM)

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: (circle as many as apply)

- A.) **Head**                      **against the:** dashboard windshield steering wheel rt door lft door seat frame unknown object
- B.) **Shoulder (L/R)**      **against the:** dashboard windshield steering wheel rt door lft door seat frame unknown object
- C.) **Arm (L/R)**            **against the:** dashboard windshield steering wheel rt door lft door seat frame unknown object
- D.) **Elbow (L/R)**        **against the:** dashboard windshield steering wheel rt door lft door seat frame unknown object
- E.) **Wrist (L/R)**         **against the:** dashboard windshield steering wheel rt door lft door seat frame unknown object
- F.) **Hip (L/R)**            **against the:** dashboard windshield steering wheel rt door lft door seat frame unknown object
- G.) **Knee (L/R)**         **against the:** dashboard windshield steering wheel rt door lft door seat frame unknown object
- H.) **Ankle (L/R)**        **against the:** 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	R / L shoulders	R / L buttocks
___ neck	R / L arms	R / L hips
___ upper/ mid back	R / L elbows	R / L thighs
___ lower back	R / L forearms	R / L knees
___ pelvis	R / L wrists	R / L legs
___ chest / rib cage	R / L hands	R / L ankles
___ abdomen	R / L 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 \_\_\_\_\_  
 Adjuster: \_\_\_\_\_  
 Claim # \_\_\_\_\_
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) \_\_\_\_\_