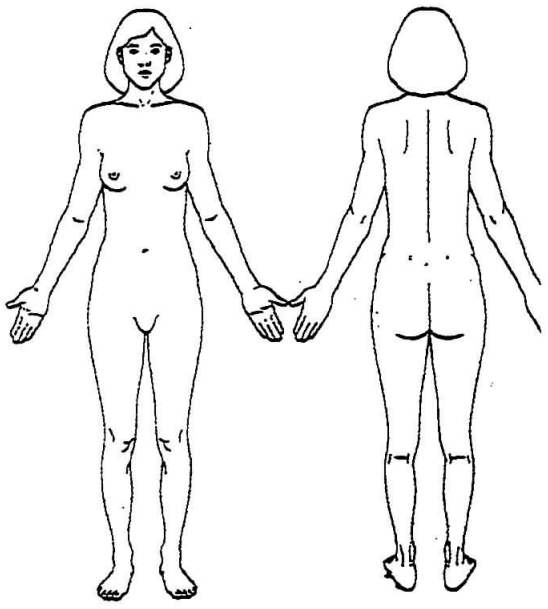
# Accident Summary Sheet

Name:_____

Today's Date: _____

Date of accident:_____
Time of accident:_____am pm
Type of accident: car home work business
Location of accident: _____
_____



**Car Accidents:**

Type of vehicle you were in: _____
Position in car: Driver Front middle Front passenger
Rear left Rear middle Rear right
Were you wearing your seatbelt? yes no
Did you lose consciousness in the accident? yes no
Were there any fatalities? yes no

**All Accidents:**

*Describe how the* accident occurred:_____
_____
_____
_____

Did you have any pain at the scene? No If yes, where?_____
_____
Did you develop pain later? No If yes, where? _____
_____
Did you go to the Emergency Room? If so, where_____
What x-rays were taken?
_____
_____
_____

What doctors have you seen?
_____

Have you had any medical procedures done?
_____

If you still have pain please indicate on the body diagram above.

What other symptoms are you having?_____
_____
_____
What medications are you taking?_____
_____
_____