ACCIDENT INFORMATION

Patient Name: _____Date of Accident: _____

Location/Road/Intersection_____

1. Where were you seated in the vehicle? _____
2. Where were your hands at the time of the accident? _____
3. What direction were you facing at the time of the accident? _____
4. What area of your vehicle was impacted? _____
5. Was Damage Considered ☐ Mild ☐ Moderate ☐ Totaled?
6. What position was your headrest in at time of accident? (Check Answer)

   ☐ High ☐ Middle ☐ Low ☐ Unknown

7. What were the Lighting Conditions? ☐ Dawn ☐ Dusk ☐ Full Daylight ☐ Night
8. What were the Road Conditions? ☐ Damp ☐ Dry ☐ Icy ☐ Snow ☐ Wet
9. What was the Visibility? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
10. What Type of Vehicle were you in? _____
11. Was your vehicle moving at the time of the Accident? ☐ Yes ☐ No
12. What was your speed at time of Accident? _____
13. What Type of Vehicle impacted yours? _____
14. What was the speed of the other vehicle? _____
15. Did Airbags Deploy? ☐ Yes ☐ No If yes, which ones? _____
16. Describe the accident to the best your ability. _____

    _____

    _____

17. How were you injured in your vehicle? (Check all that Apply)

    ☐ By being thrown from the Vehicle ☐ By the Seatbelt

    ☐ Hitting another Passenger ☐ Hitting the Back of the Front Seat

    ☐ Hit the Console ☐ Hit the Dashboard

    ☐ Hit Door ☐ Hit the Roof of the Vehicle

    ☐ Hit Steering Wheel ☐ Hit Side Window ☐ Hit Windshield

18. Did you lose consciousness following the accident? ☐ Yes ☐ No

    If Yes, for how long? _____

19. Were you aware of the Accident was going to happen? ☐ Yes ☐ No
20. Did you brace for impact? ☐ Yes ☐ No ☐ Don't Remember
21. Did you go to the hospital after the accident? ☐ Yes ☐ No
22. Did you go to an Urgent care after the accident? ☐ Yes ☐ No
23. What was the name of the facility? _____

☐ Did you go immediately after the accident?

☐ Later that day?

☐ Another date?

How did you get there? _____

24. Were X-rays taken? ☐ Yes ☐ No If so, what areas_____

25. Were any other Imaging tests performed? ☐ Yes ☐ No

26. Did you receive any medication or injections, if so, what were they? _____

_____

27. Did you receive any prescriptions for medications? ☐ Yes ☐ No

If yes, what were the names of the medications_____

_____

28. Did you fill your prescriptions? ☐ Yes ☐ No

29. Are you still taking your medications? ☐ Yes ☐ No

30. What areas of your body were injured in the accident? (Check all that apply)

☐ Back of Head Back of Neck ☐ Chest ☐ Fingers on Left Hand

☐ Fingers on Right Hand ☐ Forehead ☐ Front of Face ☐ Front of Head

☐ Front of Neck ☐ Left Arm ☐ Left Elbow ☐ Left Hand ☐ Left Hip

☐ Left Knee ☐ Left Leg ☐ Left Shin ☐ Left Shoulder ☐ Left Wrist ☐ Low Back

☐ Mid Back ☐ Nose ☐ Right Arm ☐ Right Elbow ☐ Right Hand ☐ Right Hip

☐ Right Knee ☐ Right Shin ☐ Right Shoulder ☐ Right Wrist ☐ Side of Face

☐ Side of Head ☐ Side of Neck ☐ Upper Back

31. What were your feelings following the accident? Check all that apply

☐ Anger ☐ Disoriented ☐ Dizzy ☐ Nauseous ☐ Scared ☐ Unconscious ☐ Upset ☐ Weak

32. Who have you seen since the accident for your symptoms?

☐ ER Doctor ☐ Urgent Care Doctor ☐ Primary Care Doctor ☐ Orthopedist

☐ Neurologist ☐ Pain Management Doctor ☐ Massage Therapist ☐ Acupuncturist

33. Have you lost any work due to the accident? If so, what dates?_____

Other_____

SIGNATURE: _____ DATE_____