VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION	
	Date
Patient Name	
Date of Accident	
Please describe the accident in your own words:	□ p.m.
Were you the: □ Driver □ Front Passenger □ How many people were in the accident vehicle?	
ACCIDENT SITE	IMPACT
Road/Street Name	Did your car impact another vehicle?
Make and model of vehicle you were in: Were you wearing a seatbelt?	Looking straight ahead
OTHER VEHICLE	POLICE
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? Yes No Were there any witnesses? Yes No Was a police report filed? Yes No Was a traffic violation issued? Yes No If yes, to whom?

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? Yes No When did you go? Immediately after accident Next day 2 days or more after the accident How did you get to the hospital? Name of hospital Name of doctor Diagnosis	
Treatment received	
X-rays taken	
SYMPTOMS/INJURIES	
Have you been able to work since this injury?	
How often do you have this pain?	
Activities or movements that are painful to perform: Sitting Standing Walking Bending Down	
I certify that the above information is correct to the best of my knowledge.	
Patient Signature Date	