



ACCIDENTAL INJURY REPORT

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NAME: _____ ACCT. #: _____

TODAY'S DATE: _____ DATE OF INJURY: _____ TIME: _____ A.M. P.M.

1. Were you the: Driver Passenger in the Front seat Back seat
2. How many vehicles were involved in the accident? _____
3. How many people were in your vehicle? _____
4. What direction were you headed? North South East West
On what street? _____
5. Type of accident: I was hit / I hit Head-on Broad side Rear-ended Other
6. Speed: Were you Moving _____ m.p.h. Forward Backward Stopped Braking
7. Visibility at the time of accident Good Fair Poor
8. Describe the accident in your own words: _____

9. Approximate damage done to the car you were in: \$ _____
10. Were you aware the accident was going to happen before impact? Yes No
11. Did you brace yourself for impact? Yes No
12. Head position at time of impact: Turned Right Left Looking back Straight forward
13. Body position at time of impact: Turned Right Left Straight forward
Can you recall what parts of your head or body hit what parts of your car during the accident? _____

14. Could you move all your body parts after the accident? : Yes No If no, explain: _____
15. As a result of the accident were you: Rendered unconscious Dazed, circumstances vague Shaken up, but could function
16. Have you suffered from memory loss since the accident? Yes No If yes, describe: _____
17. Were you hospitalized?: Yes No If yes, describe: _____
18. Have you been treated by a physician? Yes No If yes, describe _____
19. Have you lost time from work as a result of this accident?
If yes, list dates lost: _____ Type of employment: _____

19 Have you lost time from work as a result of this accident: Yes No

If yes, list dates lost: _____ Type of employment: _____

20 Before the accident did you have any of your present complaints? Yes No

21 Describe how you felt...

During the accident: _____

Immediately after the accident: _____

Later that day: _____

The next day: _____

22 PRESENT COMPLAINT (Please check appropriately)

- | | | |
|--|--|---|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Pins and needles in arms/legs | <input type="checkbox"/> Extreme fatigue |
| <input type="checkbox"/> Head seems too heavy | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Neuritis |
| <input type="checkbox"/> Head and Shoulders tired and heavy | <input type="checkbox"/> Eye strain/double vision | <input type="checkbox"/> Face flushed/pale |
| <input type="checkbox"/> Mental dullness | <input type="checkbox"/> Pain behind eyes | <input type="checkbox"/> Excess perspiration |
| <input type="checkbox"/> Equilibrium problems | <input type="checkbox"/> Eyes sensitive to light | <input type="checkbox"/> Digestive disorders/nausea |
| <input type="checkbox"/> Palpitation | <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Diarrhea/constipation |
| <input type="checkbox"/> Neck pain/stiffness | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Swollen _____ |
| <input type="checkbox"/> Neck motion restricted | <input type="checkbox"/> Sinus trouble | <input type="checkbox"/> Feet/hands cold |
| <input type="checkbox"/> Upper back pain/stiffness | <input type="checkbox"/> Extreme nervousness | <input type="checkbox"/> Difficulty in prolonged car riding |
| <input type="checkbox"/> Mid back pain/stiffness | <input type="checkbox"/> Anxiety | |
| <input type="checkbox"/> Low back pain/stiffness | | |
| <input type="checkbox"/> Difficulty in excessive <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Riding <input type="checkbox"/> Bending | | |
| <input type="checkbox"/> Neck, low back pain and stiffness upon rising | | |
| <input type="checkbox"/> Pain radiating into <input type="checkbox"/> Right Arm <input type="checkbox"/> Right Leg <input type="checkbox"/> Both <input type="checkbox"/> Left Leg <input type="checkbox"/> Left Arm <input type="checkbox"/> Both | | |
| <input type="checkbox"/> Difficulty in excessive lifting <input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy <input type="checkbox"/> Repetitive | | |
| <input type="checkbox"/> Pain radiating into <input type="checkbox"/> Neck <input type="checkbox"/> Base of Skull <input type="checkbox"/> Shoulder <input type="checkbox"/> Arms <input type="checkbox"/> Hips <input type="checkbox"/> Legs | | |

Please list any other present complaints and symptoms: _____

23 INSURANCE COMPANIES INVOLVED

Insurance company of party responsible for payment: _____

Claim #: _____ Phone: _____ Adjustor: _____

Your automobile insurance company: _____

Agent name: _____ Phone: _____ Do you have med-pay? Yes No

Your health group insurance company: _____

Policy #: _____ Phone: _____

Have you retained an attorney? Yes No

If yes, who? _____ Phone: _____

THANK YOU for completing this questionnaire regarding your accident. This information is necessary for the doctor in evaluating your condition. I authorize the release of any information required, and that my benefit payments be paid directly to this clinic. Please sign below that this information is true and correct.

Patient/Guardian Signature

Date

Witness