File#________

Patient Accident Report

Name:____ Date:____________

Address:__________________________________City:_________State:___Zip:_____

Phone #:________________Cell Provider:_______________

Birth Date:__________ Age:____ Sex (circle) M / F - single – married - widowed – divorced

If Female, any chance of being pregnant? (circle) Yes / No (If yes, how far along)___________

Email Address:_______________________________________

Occupation:_______________________ Employer:_______________________________________

Spouse's Name:____________________________ Name and Ages of Children:_______________________________

Emergency Contact:__________________________ Phone#:____

Date of Accident: ___________ Time: _______ Insurance Information:____________________________________

Insurance Adjuster's Name and Phone#:____

Claim #: ____

Please answer the following questions as fully as possible:

1. Your position in the car (please circle) Driver Front Passenger Rear Passenger
2. Year, make and model of vehicle were you in? __________________________________
3. Number of people in the vehicle: _______________________________________
4. Where did the accident occur? (street) _______________________________________
5. Was another vehicle involved? Yes No Make and model: _________________________
   If yes, who was at fault? ____
6. State exactly which part of your vehicle was struck: __________________________________
7. Were you aware of the oncoming accident? Yes No
8. At the moment of impact, was your vehicle (please circle) Stopped Moving Turning R or L
9. Were you wearing a seatbelt? Yes No Type: Lap Shoulder Air bag? Yes No

10. Upon impact, which way were you thrown? ____

11. Did you strike the: Steering wheel Dash Door Windshield
Other: ____

12. Were you able to get out of your vehicle and walk? Yes No

13. Have you been in a vehicle accident before? Yes No
If yes, please list date(s) and injuries: ____

14. Have you been off work due to this accident? Yes No
If yes, please list dates: ____

15. Considering the above information, describe your accident:
____
____

16. When did your symptoms first appear? (Please circle)
Immediately/right after Hours later Days later
Weeks later Months later Years later

17. Locations of pain: ____

18. Radiation (did pain move or "shoot")? Yes No

19. Type of pain (Please circle):
Sharp Stabbing Dull ache Burning
Throbbing Numbing Tightness Tingling
Other: ____________________________________

20. Did you experience any of the following symptoms? (Please circle all that apply)
Neck pain Mid back pain Lower back pain Arm or leg pain Headaches
Joint pain Stiffness Sleep difficulty Nervousness Depression
Dizziness Nausea Vomiting Bleeding
Swelling Loss of consciousness Blinding explosion feeling
Other: ____

21. Are your symptoms getting better or worse? ____

22. Were you taken to the hospital? Yes No If yes, which one?________________________

23. Were x-rays taken? Yes No Date: ______ Which body parts? ________________________

24. Have you seen any other doctor? Yes No Name of doctor(s): ______________________

25. Have you had any therapy? Yes No Where? _____________________________
Frequency: ______________________ Type: ____________________________________

Signed: ______________________________ **Date: ________________________20___**