

# VEHICLE ACCIDENT INFORMATION

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Date of accident: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time of Accident \_\_\_\_\_  a.m.  p.m.

Please describe the accident in your own words: \_\_\_\_\_  
\_\_\_\_\_

Were you the:  Driver  Front Passenger  Rear Passenger  Pedestrian

How many people were in the accident vehicle? \_\_\_\_\_

What is the name of all involved insurance companies? \_\_\_\_\_

What is the adjuster's name handling your case: \_\_\_\_\_ Phone: \_\_\_\_\_

Claim number assigned to your case: \_\_\_\_\_ Policy number: \_\_\_\_\_

## ACCIDENT SITE

Road/Street Name: \_\_\_\_\_

City/State: \_\_\_\_\_

Nearest intersection with road/street: \_\_\_\_\_

Driving conditions:  Dry  Wet  Icy  Other: \_\_\_\_\_

Which direction were you headed? \_\_\_\_\_

Speed you were traveling? \_\_\_\_\_

## VEHICLE

Make and model of vehicle you were in: \_\_\_\_\_

Were you wearing a seatbelt?  Yes  No

If yes, what type?  Lap  Shoulder

Was vehicle equipped with airbags?  Yes  No

If yes, did they inflate properly?  Yes  No

Did your seat have a headrest?  Yes  No

If yes, what was the position of the headrest?

Low  Mid-position  High

How much property damage was done to vehicle?  
\_\_\_\_\_

## IMPACT

Did your car impact another vehicle?  Yes  No

Did your car impact a structure?  Yes  No

If yes, explain: \_\_\_\_\_

Did any part of your body strike anything in the vehicle?

Yes  No If yes, explain: \_\_\_\_\_

Was impact from:  Front  Rear  Left  Right

other \_\_\_\_\_

At the time of the impact were you:

Looking straight ahead  Looking to the right

Looking to the left  Looking down

Looking up

Were both hands on the steering wheel:  Yes  No

If no, which hand was on the wheel?  Rt  Left

Was your foot on the brake?  Yes  No

If yes, which foot was on the brake?  Rt  Left

Were you:  Surprised by impact  Braced for impact

## POLICE

Did the police come to the accident site?  Yes  No

Were there any witnesses?  Yes  No

Was a police report filed?  Yes  No

If yes, do you have a copy of report?  Yes  No

Was a traffic violation issued?  Yes  No

If yes, to whom and explain: \_\_\_\_\_

## OTHER VEHICLE

Make/model of other vehicle: \_\_\_\_\_

Direction other vehicle was headed: \_\_\_\_\_

Speed other vehicle was traveling: \_\_\_\_\_

How much property damage was done to other vehicle? \_\_\_\_\_

## 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?  Immediately after accident  Next Day  2 or more days after

How did you get to the hospital?  Ambulance  Private Transportation

Name of Hospital: \_\_\_\_\_ Name of Doctor: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Treatment received: \_\_\_\_\_ X-rays taken:  Yes  No

## SYMPTOMS/INJURIES

Did this injury arise from an automobile accident?  Yes  No

Have you been able to work since this injury?  Yes  No How many days have you missed? \_\_\_\_\_

Prior to the injury were you able to work on an equal basis with others your age?  Yes  No

Please check any and all of the following symptoms you have had since your injury:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Arm/Shoulder Pain | <input type="checkbox"/> Feet/toe numbness    | <input type="checkbox"/> Neck pain           |
| <input type="checkbox"/> Back pain         | <input type="checkbox"/> Hand/Finger numbness | <input type="checkbox"/> Neck stiff          |
| <input type="checkbox"/> Back stiff        | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Chest pain        | <input type="checkbox"/> Irritability         | <input type="checkbox"/> Sleep difficulty    |
| <input type="checkbox"/> Dizziness         | <input type="checkbox"/> Jaw problems         | <input type="checkbox"/> Stomach upset       |
| <input type="checkbox"/> Ear Buzzing       | <input type="checkbox"/> Leg Pain             | <input type="checkbox"/> Tension             |
| <input type="checkbox"/> Ear Ringing       | <input type="checkbox"/> Memory Loss          | <input type="checkbox"/> Vision Blurred      |
| <input type="checkbox"/> Fatigue           | <input type="checkbox"/> Nausea               |  |

Is this condition getting progressively worse?  Yes  No  Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling:

Rate the severity of the pain on a scale from 1 (least pain) to 10 (severe pain) \_\_\_\_\_

Type of pain:

- |                                  |                                   |                                    |                                    |                                   |                                      |
|----------------------------------|-----------------------------------|------------------------------------|------------------------------------|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> Sharp   | <input type="checkbox"/> Dull     | <input type="checkbox"/> Throbbing | <input type="checkbox"/> Numbness  | <input type="checkbox"/> Aching   | <input type="checkbox"/> Shooting    |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Tingling | <input type="checkbox"/> Cramps    | <input type="checkbox"/> Stiffness | <input type="checkbox"/> Swelling | <input type="checkbox"/> Other _____ |

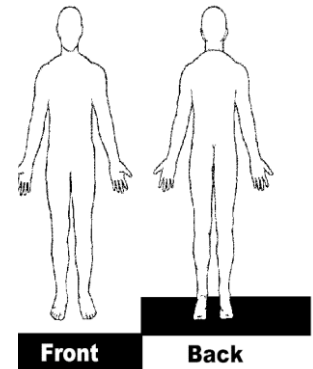
How often do you have this pain? \_\_\_\_\_

Is it constant or does it come and go? \_\_\_\_\_

Does it interfere with your:  Work  Sleep  Daily Routine  Recreation

Activities or movements that are painful to perform:  Sitting  Standing

Walking  Bending  Lying down



**I certify that the above information is correct to the best of my knowledge.**

**I authorize any insurance company that is in any way involved with any aspect of my claim to disclose any and all aspects of my claim to my doctor so that appropriate status may be determined in the processing of my claim.**

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Date**