## VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION		
	Date	
Patient Name		
Date of AccidentT		
Please describe the accident in your own words:	p.m.	
Were you the: ☐ Driver ☐ From ☐ Rear Passenger ☐ Pede	t Passenger How many people were estrian in the accident vehicle?	
ACCIDENT SITE	IMPACT	
Road/Street Name	Did your car impact another vehicle?	
If yes, what type?	Were both hands on the steering wheel?	
OTHER VEHICLE	POLICE	
(If applicable)  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?	

PATIENT CONDITION		
Were you unconscious immediately after the accident?		
TDPATMENT		
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? ☐ Ambulance ☐ Private transportation		
Name of hospital Name of doctor		
Diagnosis		
Treatment received		
X-rays taken	3 1 2 2 2 2 2 2	
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SYMPTOMS/INJURIES		
Have you been able to work since this injury?		
Mark an X on the picture where you continue to have pain, numbness, or tingling.		
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)  Type of pain:   Sharp  Dull  Throbbing  Numbness  Aching  Shooting  Burning  Tingling  Cramps  Stiffness  Swelling  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		
Movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down		
To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.		
Signature of Patient, Parent, Guardian or Personal Representative Date		
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to	Patient	