



## Accident Information

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

- ❖ Date of Accident: \_\_\_\_\_ Time of Day: \_\_\_\_\_
- ❖ Location of Accident: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_
- ❖ In your own words, please describe the accident:  
\_\_\_\_\_  
\_\_\_\_\_
- ❖ What was your position in the vehicle? \_\_\_\_\_
- ❖ Restrained? Unrestrained? \_\_\_\_\_
- ❖ Airbag deployed? (please circle) - YES / NO
- ❖ Did any part of your body contact the vehicle? (please circle) - YES / NO
  - If yes, what body part(s)? \_\_\_\_\_
- ❖ Did you lose consciousness? YES / NO
- ❖ Since the accident have you had any of the following symptoms: Circle all that apply.  
Not thinking clearly /Feeling slowed down /Not being able to concentrate /Not being able to remember new  
information /Nausea and vomiting /Headache /Fuzzy or blurry vision /Dizziness /Sensitivity to light or noise /Balance  
problems /Feeling tired or having no energy /Easily upset or angered /Sad /Nervous or anxious /More emotional  
/Sleeping more than usual /Sleeping less than usual /Having a hard time falling asleep
- ❖ Location of impact on your vehicle? \_\_\_\_\_
- ❖ What estimated speed was your vehicle moving? \_\_\_\_\_
- ❖ Vehicle damage? (please circle) - Totaled / Heavy damage / Moderate / Slight / No visible damage
- ❖ What was the estimated speed of the other vehicle(s)? \_\_\_\_\_
- ❖ Other vehicle(s) damage? (please circle) - Totaled / Heavy damage / Moderate / Slight / No visible damage
- ❖ Was your vehicle towed from the scene? (please circle) - YES / NO
- ❖ Police at the scene? (please circle) - YES / NO
- ❖ Was a Police Accident Report filed? (please circle) - YES / NO
- ❖ Was EMS at the scene? (please circle) - YES / NO
- ❖ Were you transported to the hospital? (please circle) - YES / NO
  - Driven Home? (please circle) - YES / NO
  - Drove self home? (please circle) - YES / NO
  - Continued with your activities? (please circle) - YES / NO
- ❖ Have you received any treatment since the accident? (please circle) - YES / NO -
- ❖ What Treatment?

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5233 E. Southern, #104, Mesa, AZ 85206 Ph: 480-830-2882 F: 480-830-2881  
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2824 E. Indian School Rd., Ste. 5, Phoenix, AZ 85016 Ph: 602-840-0056 F: 602-840-4056  
21323 S. Ellsworth Loop Rd. #101, Queen Creek, AZ 85142 Ph: 480-307-8440 F: 480-307-8560  
21001 N. Tatum Blvd. #78-1640, Phoenix, AZ 85050 Ph: (480) 306-7832  
13733 N. Prasad Parkway Ste #100, Surprise, AZ 85388 PH: (623) 444-7100

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- ❖ Were you given any medications? If yes, please list \_\_\_\_\_
  - ❖ Have you self-treated? If yes, how? \_\_\_\_\_

**SYMPTOMS:**

- ❖ What effects did the accident have upon you? (physically & emotionally):
  - during the accident: \_\_\_\_\_
  - immediately after the accident: \_\_\_\_\_
  - later that day: \_\_\_\_\_
  - the next day: \_\_\_\_\_
- ❖ What are your present complaints and symptoms?
  - \_\_\_\_\_

**WORK:**

- ❖ As a result of the accident, have you lost work time? ☐ No ☐ Yes
  - If yes, please complete the following:
  - Date last worked: \_\_\_\_\_
  - Have you noticed any limitations when performing your job?  
If yes, please explain: \_\_\_\_\_
- ❖ Are you concerned about the affect of this accident on your job?
  - If yes, please explain: \_\_\_\_\_

**RELATIONSHIPS:**

- ❖ Have you noticed any new or increasing stresses at home with your significant other, children, siblings, parents, co-workers?
  - If yes, please explain: \_\_\_\_\_
  - Are you able to manage or do you need assistance? \_\_\_\_\_

**PERSONAL LIFE:**

- ❖ Have you had any difficulties performing everyday activities? (For example; grooming, bathing, child care, reading, shopping, driving...)
  - If yes, please explain : \_\_\_\_\_
- ❖ Have you had any difficulty performing any duties around your home? (For example; yard work, cleaning, car care...)
  - If yes, please explain: \_\_\_\_\_
- ❖ Have you had any difficulties performing any recreational activities/hobbies? (For example; working out at the gym, hiking, tennis, golf, swimming, yoga...)
  - If yes, please explain: \_\_\_\_\_

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**Patient Signature**

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