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?**

_____

_____

- **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:_____**

_____

Patient Signature