

# ACCIDENT



Patient Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Sex: \_\_\_\_\_ S.S.#: \_\_\_\_\_  
Employer's Name \_\_\_\_\_ Employer's Address \_\_\_\_\_  
Your Ins. Co.: \_\_\_\_\_ Policy# \_\_\_\_\_ Agent's Name \_\_\_\_\_  
Name on Policy (If other than self) \_\_\_\_\_ Policy# \_\_\_\_\_  
Responsible Party's Name \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Policy Holder's Name \_\_\_\_\_ Policy# \_\_\_\_\_  
Attorney's Name \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Date of Accident: \_\_\_\_\_

Type of Accident:  Automobile  Initial Evaluation  Slip and Fall  
 Workers Compensation  Follow-up Evaluation  Final Evaluation

In your own words, describe the accident / history of present illness:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

<p><b>Date of accident:</b> _____</p> <p><b>Your position was:</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Driver</li><li><input type="checkbox"/> Front Passenger</li><li><input type="checkbox"/> Left rear passenger</li><li><input type="checkbox"/> Right rear passenger</li><li><input type="checkbox"/> Middle front passenger</li><li><input type="checkbox"/> Middle rear passenger</li></ul> <p><b>Time of accident:</b> _____ : _____ AM / PM</p> <p><b>Location of accident:</b> _____</p> <p><b>Your vehicle speed:</b> _____ MPH</p> <p><b>Other vehicle speed:</b> _____ MPH</p> <p><b>Damage to your vehicle:</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Mild</li><li><input type="checkbox"/> Moderate</li><li><input type="checkbox"/> Extensive</li><li><input type="checkbox"/> Totaled</li></ul> <p><b>Visibility:</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Poor</li><li><input type="checkbox"/> Fair</li><li><input type="checkbox"/> Good</li></ul> <p><b>The weather was:</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Snowing <input type="checkbox"/> Raining <input type="checkbox"/> Windy</li><li><input type="checkbox"/> Foggy <input type="checkbox"/> Clear</li></ul> <p><b>Who hit who / what:</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> You hit other vehicle</li><li><input type="checkbox"/> You hit other object</li><li><input type="checkbox"/> Other vehicle hit you</li></ul>	<p><b>Point of impact:</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Front <input type="checkbox"/> Left front <input type="checkbox"/> Side</li><li><input type="checkbox"/> Right Front <input type="checkbox"/> Rear</li></ul> <p><b>Were you using a seat belt?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>Were you using the shoulder harness?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>Does the vehicle have an airbag?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>Did it deploy?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>Did you strike anything in the vehicle?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>If yes, what?</b> <input type="checkbox"/> Wheel <input type="checkbox"/> Windshield <input type="checkbox"/> Armrest <input type="checkbox"/> Side door <input type="checkbox"/> Dashboard <input type="checkbox"/> Side window <input type="checkbox"/> Airbag <input type="checkbox"/> Other _____</p> <p><b>Where? (Part of the body):</b> _____</p> <p><b>Did you see the accident coming?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>Does the vehicle have headrests?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>What position were they in?</b> <input type="checkbox"/> Even with top of head <input type="checkbox"/> Even with bottom of head <input type="checkbox"/> Middle of neck</p>
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# ACCIDENT 2

- Were you braced for the impact?**  Yes  No  
**Were you dazed?**  Yes  No  
**Did you hit your head?**  Yes  No  Not sure  
**Was your head injured?**  Yes  No

If yes, where? \_\_\_\_\_

- Did you lose consciousness**  Yes  No

**If yes, for how long?** \_\_\_\_\_

**Other body parts injured:** \_\_\_\_\_

**Immediately after the accident, you experienced:**

- Headaches  Neck pain  Low back pain  Nothing

Other: \_\_\_\_\_

- Did you go to the hospital?**  Yes  No

If yes, where? \_\_\_\_\_

- How did you get there?**  Ambulance  Somebody else  
 Drove self  Police

**Tests done at the hospital:**

X-Rays Where? \_\_\_\_\_

MRI Where? \_\_\_\_\_

CT-Scan Where? \_\_\_\_\_

Lab work Where? \_\_\_\_\_

Other test: \_\_\_\_\_

- Any other doctor seen for this accident?**  Yes  No

**Name: Dr.** \_\_\_\_\_

**Treatment/Tests performed** \_\_\_\_\_

**Name 2: Dr.** \_\_\_\_\_

**Treatment/Tests performed** \_\_\_\_\_

**Name 3: Dr.** \_\_\_\_\_

**Treatment/Tests performed** \_\_\_\_\_

**Since the accident are you:**

- Better  Same  Worse

**If yes, for how long?** \_\_\_\_\_

**Since the accident have you had problems with:**

- Seeing  Tasting  Smelling  Eating  
 Hearing  Bathing  Grooming  Dressing  
 Reading  Typing  Writing  Grasping  
 Holding  Pinching  Standing  Leaning  
 Walking  Stooping  Squatting  Climbing  
 Kneeling  Bending  Twisting  Carrying  
 Lifting  Pushing  Pulling  Reaching  
 Sitting  Driving  Riding Car  Plane Travel  
 Sports  Exercising  Loss of sexual drive

**Signature:** \_\_\_\_\_

- Reclining  Restful sleeping  Insomnia  Irritable

- Using the toilet  Loss of concentration

- Nervous  Change in personality

- Tactile feeling  Talking

- Can go to sleep without problems?**  Yes  No

- Awaken because of pain?**  Yes  No

**If yes, where?** \_\_\_\_\_

- Had sleep problems before?**  Yes  No

- Can you perform physical work activities?**  Yes  No

- If no, Why?**  Pain  Weakness  Stress

Other \_\_\_\_\_

**Patient's Occupation:** \_\_\_\_\_

- Current Duty:**  Light Duty  Regular Duty

- Off Duty, If so, How Long?

- Financial burden for patient and family?**  Yes  No

**If yes, please explain:** \_\_\_\_\_

- Have you been in an accident before?**  Yes  No

**If yes, in (year)** \_\_\_\_\_

**Doctor who treated, Dr.** \_\_\_\_\_

**Details:** \_\_\_\_\_

- Any residual problems?**  Yes  No

**Explain:** \_\_\_\_\_

## SECOND ACCIDENT

**If yes, in (year)** \_\_\_\_\_

**Doctor who treated, Dr.** \_\_\_\_\_

**Details:** \_\_\_\_\_

- Any residual problems?**  Yes  No

**Explain:** \_\_\_\_\_

## THIRD ACCIDENT

**If yes, in (year)** \_\_\_\_\_

**Doctor who treated, Dr.** \_\_\_\_\_

**Details:** \_\_\_\_\_

- Any residual problems?**  Yes  No

**Explain:** \_\_\_\_\_

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