ACCIDENT INFORMATION

Patient Name ____ Date _______________________

Date of Accident ______________________________ Time of Accident _____________

Type of accident: ____ Auto accident ____ Work related Other ______________________________

Location of accident ____

Have you missed any work? ____ Yes ____ No If yes, how many days? ______________________

Describe the circumstances surrounding accident: ____

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Auto Accident:

What kind of vehicle was involved? ____

Were you a ____ Driver? ____ Passenger? ____ Pedestrian?

If a passenger, please indicate you location in the car _____________________________________

Was your vehicle moving when the accident occurred? ____ Yes ____ No ________ mph

Did your vehicle hit another vehicle(s)? ____ Yes ____ No Where? _____________________

Did other vehicle(s) hit your vehicle? ____ Yes ____ No Where? _______________________

Did you see the accident coming? ____ Yes ____ No

At the time of impact, which direction were you looking? __________________________________

Were both hands on the steering wheel? ____ Yes ____ No

Were you wearing a seat belt? ____Yes ____ No

Were you wearing a shoulder harness? ____ Yes ____ No

Did the car you were in have airbags? ____ Yes ____ No Did they deploy? ____Yes ____No

Was the accident reported to the police? ____ Yes ____No

Were traffic citations issued? ____ Yes ____ No To whom? ____________________________

Did you go to the ____ Emergency Room ____ Urgent Care Other _______________________

Work Related Accident:

Employer ________________________________ Type of business _________________________

Was any equipment, machinery and/or object related to accident? ________________________

Was accident reported to supervisor and/or employer? ____ Yes ____ No

Has a worker's compensation claim been filed? ____ Yes ____ No

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Doctor's Notes:

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