VEHICLE COLLISION FORM

PATIENT INFORMATION

Patient Name: _____ Today's Date: _____
Date of Accident: _____ Time of Accident: _____
Please describe the accident in your own words: _____
_____
_____

Were you the: ○Driver ○Front passenger ○Rear passenger ○Pedestrian
How many people were in the vehicle? _____

ACCIDENT SITE

Road/Street Name: _____ City/ State:_____
Nearest intersection with road/ street: _____
Driving conditions were: ○ Dry ○ Wet ○ Icy ○ Other _____
Which direction were you heading: _____ Speed you were traveling: _____

VEHICLE

Make and model of vehicle you were in: _____
Where you wearing a seatbelt? ○ Yes ○ No If yes, which kind: ○ Lap ○ Shoulder
Was vehicle equipped with airbags? ○ Yes ○ No If yes, did it/ they inflate properly? ○ Yes ○ No
Did your seat have a headrest? ○ Yes ○ No If yes, which position was the headrest? ○ Low ○ Midposition ○ High

OTHER VEHICLE

Make and model of other vehicle: _____
Which direction was other vehicle headed? _____ Speed other vehicle was traveling: _____

IMPACT

Did your car impact another vehicle? ○ Yes ○ No
Did your car impact a structure? ○ Yes ○ No If yes, explain: _____
Did any part of your body strike anything in the vehicle? If yes, explain: _____
Was impact from: ○ Front ○ Rear ○ Left ○ Right ○ Other_____
At the time of impact were you: ○ Looking straight ahead ○ Looking to the right ○ Looking to the left ○ Looking up ○ Looking down
Were both hands on the steering wheel? ○ Yes ○ No If no, which had was on the wheel? ○ Right ○ Left
Was your foot on the brake? ○ Yes ○ No if yes, which food was on the brake? ○ Right ○ Left
Were you: ○ Surprised by impact ○ Braced for impact

POLICE

Did the police come to the accident site? ○ Yes ○ No Was there a police report filed? ○ Yes ○ No
Was a traffic violation issued? ○ Yes ○ No If yes, to whom? _____
Were there witnesses? ○ Yes ○ No

PATIENT CONDITION

What is the first thing you remember after the accident? _____
Were you unconscious immediately after the accident? ○ Yes ○ No If yes, for how long?_____
Please describe how you felt immediately after the accident: _____

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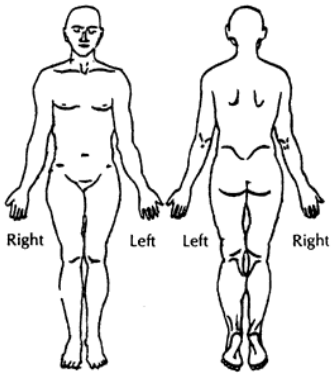
TREATMENT

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: _____

SYMTPOMS/ INJURIES

Have you been able to work since the injury? ○ Yes ○ No How many days have you missed? _____
Prior to the injury were you able to work on an equal basis with others your age? ○ Yes ○ No
If you have had any following symptoms since your injury, please check:

○ Arm/ shoulder pain
○ Back pain
○ Back stiffness
○ Chest pain
○ Dizziness
○ Ear buzzing
○ Ear ringing
○ Fatigue
○ Feet/ toe numbness
○ Hand/ finger numbness
○ Headaches
○ Irritability
○ Jaw problems
○ Leg pain
○ Memory loss
○ Nausea
○ Neck pain
○ Neck stiff
○ Shortness of breath
○ Sleep difficulty
○ Stomach upset
○ Tension
○ Vision blurred



Is this condition getting progressively worse? ○ Yes ○ No ○ Unknown
Mark an X on the picture where you continue to have pain, numbness, or tingling.
Rate the severity of your pain on a scale of 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
Activities or movements that are painful to perform: ○ Sitting ○ Standing ○ Waking ○ Bending ○ Lying down
How long are you able to do these activities before pain starts? _____

Billing Information

Insurance Company:_____ Claim Number: _____

Adjuster Name : _____ Phone #: _____

I certify that the above information is correct to the best of my knowledge:

Patient signature: _____ Date: _____