Vehicle Accident Report

Name of patient: _____ Date of Accident: _____

1. During the accident, were you the: ◯ driver ◯ front passenger ◯ back passenger ◯ pedestrian

2. Time of accident: _____ ◯ am ◯ pm

3. Location of accident: _____

4. Patient's vehicle speed _____mph

5. Other vehicle's speed _____mph

6. Damage to your vehicle: _____

7. Visibility: ◯ snowing ◯ raining ◯ windy ◯ foggy ◯ clear

8. Who hit who/what? _____

9. What object? _____

10. Point of impact: ◯ Front ◯ left front ◯ right front ◯ rear ◯ left rear ◯ right rear
◯ left side ◯ right side

11. Were you wearing your seatbelt? ◯ yes ◯ no

12. Were you using the shoulder harness? ◯ yes ◯ no

13. Does the vehicle have an airbag? ◯ yes ◯ no

14. Was the airbag deployed? ◯ yes ◯ no

15. Did you strike anything on the vehicle? ◯ yes ◯ no

15a. If yes, what? ◯ gear shift level/knob ◯ seatback ◯ airbag ◯ headrest ◯ side door
◯ armrest ◯ rearview mirror ◯ side window ◯ center console ◯ roof ◯ wheel
◯ dashboard ◯ rear window ◯ windshield ◯ other: _____

15b. Where? (part of the body) _____

16. Did you see the accident coming? ◯ yes ◯ no

17. Does the vehicle have headrests: ◯ yes ◯ no

18. What position? _____

19. Were you braced for the impact? ◯ yes ◯ no

20. Were you dazed? ◯ yes ◯ no

21. Did you lose consciousness? ◯ yes ◯ no If yes, for how long? _____

22. Direction of head on impact: _____

23. Was the head injured? ◯ yes ◯ no

24. Other part(s) injured: _____
Bruises: _____
Abrasions: _____
Lacerations: _____
Swelling: _____
Bleeding: _____
Fracture: _____
Burns: _____

25. Immediately after the accident patient experienced: ◯ headaches ◯ neck pain ◯ low back pain
and pain in _____

26. Did you go to the hospital? ◯ yes ◯ no If yes, which one? _____
Transportation to the hospital by: _____

27. Tests done at the hospital: ◯ X-rays ◯ MRI ◯ CT-SCAN ◯ Lab Work
Other test: _____

28. Any prior doctor for this accident? ◯ yes ◯ no
Name: Dr. _____ Tests/Procedures: _____
Name2: Dr. _____ Tests/Procedures: _____
Name3: Dr. _____ Tests/Procedures: _____

29. Your condition: _____
Have you lost time from work? ◯ yes ◯ no If yes, for how long? _____

30. Can you perform physical work activities? ◯ yes ◯ no
If no, why? ◯ pain ◯ Weakness ◯ stress ◯ other: _____

31. I am having 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 ◯ air travel ◯ sports
◯ exercising ◯ reclining ◯ loss of sexual drive ◯ restful sleeping ◯ Insomnia
◯ Using the toilet ◯ Loss of concentration ◯ Nervous ◯ Irritable ◯ Change in personality
◯ Tactile feeling ◯ Additional comments: _____

32. Can I go to sleep without problems? ◯ yes ◯ no If yes, where? _____

33. Did I have sleep problems before? ◯ yes ◯ no

34. My occupation: _____ Duty: _____

35. Financial burden for self and family? ◯ yes ◯ no If yes, explain: _____

36. Past accidents? ◯ yes ◯no If yes, what year? _____ Dr. who treated: _____

37. Details of accident: _____
_____

38. Other accident information: _____