

ACCIDENT REPORT

Name _____ Date of accident _____ Time _____

Type of Injury: Auto _____ Work _____ Fall _____ Other _____

Where did accident happen? _____

Did weather play any part in the accident? _____

Describe your symptoms in detail: (circle all that apply)

General Symptoms

Nervousness _____ Loss of sleep _____ Fatigue _____ Depression _____
 Irritability _____ Tension _____ PMS _____ Jaw Pain _____

Head

Headaches mild _____ moderate _____ severe _____
 How Often _____ times per day / week _____ month _____

Are they?
 Sharp _____ dull _____ constant _____ intermittent _____

Where are they located?
 Back _____ forehead _____ temples _____
 right _____ left _____ behind eyes _____

Light headed _____ sensitivity to light _____
 Memory loss _____ loss of balance _____
 Blurred vision _____ hearing loss _____
 Double vision _____ ringing in ears _____

Neck

Pain: Left side _____ right side _____ both _____
 Mild _____ moderate _____ severe _____

Increased by:
 Forward movement _____ backward movement _____
 Rotation of neck _____ bending of neck _____
 Stiffness _____
 muscle spasm _____
 grinding/grating sound _____

Shoulder

Pain in joint left _____ right _____ both _____
 Pain across shoulder left _____ right _____ both _____
 Limitation of movements left _____ right _____ both _____

Arms

Upper arms
 Pain left _____ right _____ both _____
 Pins and needles left _____ right _____ both _____
 Numbness left _____ right _____ both _____
 Elbow left _____ right _____ both _____

Forearm
 Pain left _____ right _____ both _____
 Pins and needles left _____ right _____ both _____
 Numbness left _____ right _____ both _____

Hands
 Wrist pain left _____ right _____ both _____

Hand
 Pain left _____ right _____ both _____
 Pins and needles left _____ right _____ both _____
 Numbness left _____ right _____ both _____

Mid back

Pain left _____ right _____ both _____
 mild _____ moderate _____ severe _____

Spasm left _____ right _____ both _____
 mild _____ moderate _____ severe _____

Chest

Chest pain left _____ right _____ both _____
 mild _____ moderate _____ severe _____

Rib pain left _____ right _____ both _____
 Shortness of breath _____
 Irregular heartbeat _____

Low back

Pain left _____ right _____ both _____

Spasm left _____ right _____ both _____

Hips and legs

Pain in buttocks left _____ right _____ both _____
 Mild _____ moderate _____ severe _____

Pain in Hip left _____ right _____ both _____
 Mild _____ moderate _____ severe _____

Knee pain left _____ right _____ both _____
 Mild _____ moderate _____ severe _____

Leg Cramp left _____ right _____ both _____
 Mild _____ moderate _____ severe _____

Feet

Ankle pain/swelling left _____ right _____ both _____
Foot pain/cramps left _____ right _____ both _____
Numbness left _____ right _____ both _____
Swelling left _____ right _____ both _____

Are your symptoms getting:
 Worse _____ Better _____ Same _____

Have you seen another doctor for these symptoms?

Name / Address _____

Did you have any of these symptoms prior to this injury? _____

If so please explain _____

Any additional information _____

For present injury, have you missed any work? _____ If yes, dates missed _____

Dates of limited work _____ Date returned to full work _____

Were you capable of working on an equal basis prior to this present injury? _____

The present injury was due to an auto accident, were you the driver - passenger (front) - (back) -
or pedestrian. Were you wearing a seat belt? _____

Your Vehicle? Auto Truck Van Motorcycle Motorhome Bicycle Other _____

How accident occurred? Struck by another vehicle _____ You struck another vehicle _____

You struck a stationary object _____ Other _____

Where was you vehicle hit? Front _____ Rear _____ Rt. Side _____ Lt Side _____ Rt Front _____

Lt front _____ Rt. Rear _____ Lt. Rear _____ Approximate speed _____ Other Vehicle _____

What occurred at impact? Tensed for impact _____ neck whipped forward and back _____

Spine torqued and twisted _____ Thrown over seat _____ Thrown from vehicle _____

Pinned in vehicle _____ Thrown side to side _____ Cut and bruised _____

Did you strike?

Head (against dash, windshield, steering wheel, right door, left door, seat frame, other)

Shoulder Lt / Rt dash, windshield, steering wheel, right door, left door, seat frame, other

Arm Lt / Rt dash, windshield, steering wheel, right door, left door, seat frame, other

Elbow Lt / Rt dash, windshield, steering wheel, right door, left door, seat frame, other

Wrist Lt / Rt dash, windshield, steering wheel, right door, left door, seat frame, other

Hip Lt / Rt dash, windshield, steering wheel, right door, left door, seat frame, other

Knee Lt / Rt dash, windshield, steering wheel, right door, left door, seat frame, other

Ankle Lt / Rt dash, windshield, steering wheel, right door, left door, seat frame, other

Were you knocked unconscious? _____ Did you receive medical attention? _____

Where did you go immediately after the accident? Hospital _____ home _____ doctor _____

this office _____ resumed regular activities _____.

Comments: _____

By signing below, I acknowledge that the information is true to the best of my knowledge.

Signature _____ Date _____