VEHICLE ACCIDENT INFORMATION

Name:_____ Date of accident:_____

Time of accident:_____ Location:_____

Were you the: ☐ driver ☐ front passenger ☐ rear passenger ☐ pedestrian
Were you wearing a seatbelt? ☐ yes ☐ no If yes, what type? ☐ lap ☐ shoulder ☐ both

Was the vehicle equipped with airbags? ☐ yes ☐ no ☐ don't know/does not apply
If yes, did it/they inflate properly? ☐ yes ☐ no ☐ don't know

Did your seat have a headrest? ☐ yes ☐ no ☐ don't remember
If yes, which position was it in? ☐ low ☐ mid position ☐ high ☐ don't remember

Did your car impact another vehicle? ☐ yes ☐ no
Did your car impact a structure? ☐ yes ☐ no (if yes, describe:_____)
Was impact from: ☐ rear ☐ front ☐ driver's side ☐ passenger's side ☐ other_____

Did you go to the hospital? ☐ yes ☐ no By ambulance? ☐ yes ☐ no

Have you been able to work since your injury? ☐ yes ☐ no How many days missed?_____

If you have had any of the following symptoms since your injury, please check the box:

☐ arm/shoulder pain	☐ foot/toe numbness	☐ neck pain
☐ back pain	☐ hand/finger numbness	☐ neck stiffness
☐ back stiffness	☐ headaches	☐ shortness of breath
☐ chest pain	☐ irritability	☐ sleep difficulty
☐ dizziness	☐ jaw problems	☐ stomach upset
☐ ear buzzing R L	☐ leg pain R L	☐ tension
☐ ear ringing R L	☐ memory loss	☐ vision blurred
☐ fatigue	☐ nausea	

☐ other:_____

Does the above symptom(s) interfere with your: ☐ work ☐ sleep ☐ daily routine ☐ recreation

Activities that are painful to perform: ☐ sitting ☐ standing ☐ walking
☐ bending ☐ lying down ☐ other_____

Insurance company:_____ Phone(____)_____

Address:_____ Insured person's name:

_____ _____

Policy#_____ Claim#_____

Adjuster handling case: _____

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

Patient's signature:_____ Date:_____