CONFIDENTIAL VEHICLE ACCIDENT REPORT

Name__ _____ _____ _____ _____ **Social Security #**_____ ___ **File #**_ ____ __

Address _____ _____ _____ **City** _____ **State** _____ **Zip**_____.

Home Phone __ _____ _____ **Birthdate** _____ **Age** _____

Driver's license #_ _____ _____ _____ **Marital Status:** M S W D **Sex** M F **Children** _____None__

Occupation _____ _____ _____ **Work Address** _____ ____ ___

Work Phone # _ _____ **Email:** _____ ____ ____

Nearest Relative: Name & Telephone _____ ____ ____ ____ ___

Date of accident_ _____ _____ **Time of Accident**_____(AM/PM)

Were you: A) Driver __ B) Passenger (Front)__ C)Passenger (Rear)__ (D)Pedestrian___ Number of people in vehicle___

Were you wearing a shoulder harness? ___Yes ___No **Were you wearing seatbelts?** ___Yes ___No

Your vehicle: A)Auto B)Truck C) Van D)Motorcycle E)Motor Home F)Bicycle Other _____ _____ _

Year and model of your car_____ **Who owns the vehicle**_____ _____

What was the approximate damage done to the car you were in? $_____ **Was it driveable?** ___Yes ___No

Other vehicle: A)Auto B)Truck C) Van D)Motorcycle E)Motor Home F)Bicycle Other _____ _____

Other vehicle year of model___ _____ **Who owns the vehicle**_____ ____.

Visibility at time of accident: ___ poor ___ fair ___good

Road conditions at time of accident: ___dry ___wet ___rainy ___snow ___ice ___fog ___clear ___dark

How accident occurred: A)Struck by another vehicle B)Struck another vehicle C)Struck stationary object D)Other_ ____

Where was your vehicle hit:A)Front B)Rear C)Rt Side D)Lt Side E)Rt Front F)Lt Front G)Rt Rear H)Lt Rear

Other vehicle contact:A)Front B)Rear C)Rt Side D)Lt Side E)Rt Front F)Lt Front G)Rt Rear H)Lt Rear

In your own words please describe the accident:_____ _____ ____ _

_____ ____ _____ _____

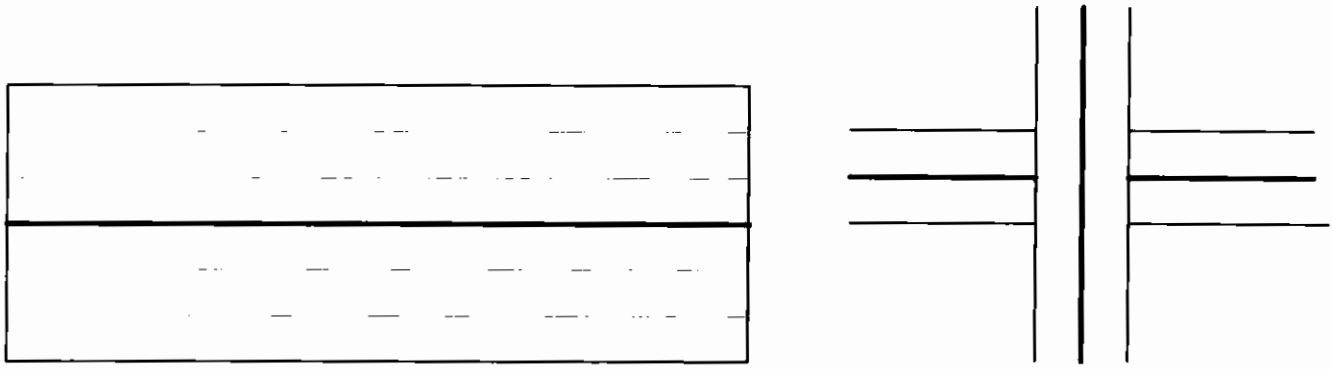
_____ _____ _____ _____ _____ _____

_ ____ _____ _____ _____ _____ ____ __

____ _____ _____ _____ _____ _____ _____

_ _____ _____ _____ _____ ____ ___

INDICATE ON APPROPRIATE DIAGRAM HOW THE ACCIDENT HAPPENED:



Did you see the accident coming? ___ Yes ___No
Were you pre-warned that the accident was about to happen? ___Yes ___No

Did you brace for impact? ___Yes ___No

Does your car have headrests? ___Yes ___No

If yes, what was the position of those headrests compared to your head before the accident? ___ Top of headrest even with bottom of head ___ Top of headrest even with top of head ___ Top of headrest even with middle of neck.

Was the car you were in braking? ___Yes ___No

Your approximate speed ____mph **Other vehicle's approximate speed** _____mph

What occurred at the moment of impact? (Circle as many as apply)

A)Tensed Body for impact	B)Neck whipped forward and back	C)Spine torqued and twisted
D) Thrown over seat	E)Thrown from vehicle	F) Pinned in vehicle
G) Thrown from side to side	H) Cut and bruised	I) Other_____ _____ ___

What was your head position at the time of impact?
Head turned: ___Right ___Left ___Looking back ___Straight ahead
Body rotated: ___Right ___Left

Did you strike your: (Circle as many as apply)

A)Head	Against:	Dashboard	Windshield	Steering Wheel	Rt Door	Lt Door	Head Rest	Unknown object
B) Shoulder	Against:	Dashboard	Windshield	Steering Wheel	Rt Door	Lt Door	Seat Frame	Unknown object
C) Arm	Against:	Dashboard	Windshield	Steering Wheel	Rt Door	Lt Door	Seat Frame	Unknown object
D) Elbow	Against:	Dashboard	Windshield	Steering Wheel	Rt Door	Lt Door	Seat Frame	Unknown object
E) Wrist	Against:	Dashboard	Windshield	Steering Wheel	Rt Door	Lt Door	Seat Frame	Unknown object
F) Hip	Against:	Dashboard	Windshield	Steering Wheel	Rt Door	Lt Door	Seat Frame	Unknown object
G) Knee	Against:	Dashboard	Windshield	Steering Wheel	Rt Door	Lt Door	Seat Frame	Unknown object
H) Ankle	Against:	Dashboard	Windshield	Steering Wheel	Rt Door	Lt Door	Seat Frame	Unknown object

Were you rendered unconscious? ___Yes ___No

Were you able to move all of your body parts? ___Yes ___No If no, explain_____ _____ __

Were you able to get out of the car unaided? ___Yes ___No If no, explain_____

Did you bleed or get cuts and bruises? ___Yes ___No If yes, Bleeding_____Cuts/bruises_____

Were there any flying objects in the car? _____ Were you hit? _____ Where? _____

Please describe how you felt:

A. DURING the accident:_____

B. IMMEDIATELY AFTER the accident: _____

C. LATER THAT DAY: _____

D. THE NEXT DAY: _____

CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

__ Headache	__Dizziness	__Light bothers eyes	__Cold sweats
__Neck pain	__Head heavy	__Loss of memory	__Feet cold
__Neck stiffness	__Pins/Needles in arms	__Ears ring	__Hands cold
__Sleeping problems	__Pins/Needles in legs	__Face Flush	__Stomach upset
__Numbness in Fingers	__Buzzing in ears	__Constipation	__Loss of taste
__Mid back pain	__Nervousness	__Loss of balance	__Diarrhea
__Low back pain	__Numbness in toes	__Tension	__Shortness of breath
__Fainting	__Fever	__Loss of smell	__Vomit
__Irritability	__Fatigue	__Chest pain	__Depression

Symptoms other than above: _____

_____

PAIN LEVEL: On a scale of 0 - 10, with 0 being pain free and fully functional, and 10 being constant agony and total inability to function, where would you rate yourself?

0 1 2 3 4 5 6 7 8 9 10

No pain Moderate pain Excruciating pain

INDICATE ABILITY TO PERFORM THE FOLLOWING ACTIVITIES:

U=Unable **P**=Painful **D**=Difficult **L**=Limited **N**=Normal

__Coughing or sneezing	___Lying on side	___Gripping
___Getting in/out of car	___Bending forward	___Pushing
___Bending to brush teeth	___Climbing stairs	___Pulling
___Turning over in bed	___Kneeling	___Reaching
__Walking short distances	___Balancing	___Sexual activity
__Standing for more than 1 hour	___Dressing self	___Stooping
___Lying on back	___Sleeping	___Lying on stomach
___Sitting at table	___Other_____	

_____

Have you lost any time from work as a result of this accident? ___Yes ___No If yes, please complete below:

a. Last day worked: _____

b. Type of employment: _____

c. Are you being compensated for time from lost work? ___Yes ___No

Was a police report filed? ___Yes ___No **Were you taken by ambulance to the hospital**?__Yes __No

Did you receive medical attention at the scene of the accident? ___Yes ___No

If yes what was done? _____

Were you taken by ambulance to the hospital?___Yes ___No If yes, where?_____
What was done?_____
What was the diagnosis given?_____

Where did you go immediately after the accident? A) Resumed activities B) Home C) This office
A) Medical attention: Where? _____Were you examined? ___ Yes ___ No
Were you x-rayed? _ Yes ___No If yes, what area? _____ What treatment was given? _____
Date of treatment_____

Second Doctor/Clinic seen:_____**Date of first visit:**_____
Were you examined? ___Yes ___No **Were X-rays taken?** ___Yes ___No

Were you given treatment? ___Yes ___No If yes, explain_____

What benefits did you receive from the treatment?_____

Date of last treatment:_____

Did you have any physical complaints before the accident? ___Yes ___No If yes please describe:
_____
_____
_____

Have you ever been involved in an accident before? ___Yes ___No If yes, describe and indicate date:
_____
_____

List surgical operations and years _____
_____
_____

Drugs you now take : None__ Nerve pills __ Pain killers __ Muscle relaxers __
"Pep" pills __Tranquillizers__ Insulin __ Birth control pills __ Others_____

Do you **smoke?**- packs per day_____ for how long?_____
drink alcohol? - drinks per day _____
use caffeine? - cups per day _____
exercise regulary? - what exercises _____

During the day (at work or at home) do you: ___ sit ___ compute ___desk; ___stand in one position
lift ___> 25lbs. ___< 25lbs Explain_____
_____

Have you ever suffered from:
Dizziness _____Backaches _____ Heart trouble_____ Diabetes _____
Arthritis _____ Headaches _____ Asthma _____ Digestive Disorders _____
Nervousness _____ Sinus Trouble _____ Neck Pain _____

FAMILY MEDICAL HISTORY: Has any family member (parents, brothers, sisters, grandparents) had any of the following disorders: **Please list family member next to disorder:**
High blood pressure___ _____ Heart Disease_____
Cancer__ _____ _____ Diabetes_____
Thyroid_____ _____ _____ Kidney_____
Arthritis _____ _____ _____ Tuberculosis_____
Stroke_____ _____ Lung Disease_____