VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Date_____

Patient Name_____ Sex: Male or Female (circle one)

Name of Parent if under 18 yrs. old _____

Street Address _____

City _____ State _____ Zip _____ Home Phone #_____–_____–_____

Age _____ D.O.B. ___/___/___ Soc. Sec. # ___/___/___ Cell Ph. # _____

Marital Status ___Mar. / ___Sin. / __Wid. / __Div. Spouse's Name _____

Date of Accident_____ Time of Accident_____ ☐ a.m. ☐ p.m.

State Accident Took Place in: Rhode Island _____ / Mass _____ / Other - List _____

Have you missed time from work because of this accident? ☐ Yes ☐ No Last Date Worked _____

Name of Your Employer _____ Employer Phone #_____

Employer Address _____

Employer Phone # _____

ATTORNEY / AUTO INS. INFO

Attorney's Name _____

Attorney's Address_____

Attorney's Phone # _____

Auto Insurance Name _____

Auto Insurance Phone # _____

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger ☐ Pedestrian

How many people were in the accident vehicle?_____

VEHICLE

Make and model of vehicle you were in:

_____

Were you wearing a seatbelt? ☐ Yes ☐ No

If yes, what type? ☐ 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, what was the position of the headrest?

☐ Low ☐ Midposition ☐ High

POLICE

Did the police come to the accident site? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Was a traffic violation issued? ☐ Yes ☐ No

If yes, to whom?_____

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?

☐ Yes ☐ No 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 down

☐ Looking up

Were both hands on the steering wheel? ☐ Yes ☐ No

If no, which hand was on the wheel? ☐ Right ☐ Left

Was your foot on the brake? ☐ Yes ☐ No

If yes, which foot was on the brake? ☐ Right ☐ Left

Were you: ☐ Surprised by impact ☐ Braced for impact

– OVER –

ACCIDENT DESCRIPTION

Please describe how the accident happened in your own words: _____

_____

_____

_____

TREATMENT

Did you go to the hospital? ☐ Yes ☐ No Name of Hospital _____

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

Were X-rays taken? ☐ Yes ☐ No Name of doctor _____

SYMPTOMS/INJURIES

Have you been able to work since this injury? ☐ Yes ☐ No How many work days have you missed?_____

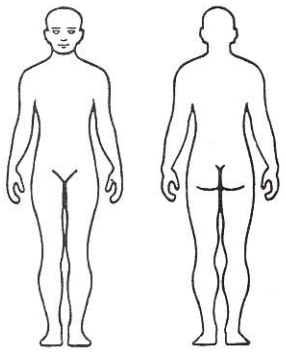
Prior to the injury were you able to work on an equal basis with others your age? ☐ Yes ☐ No

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

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

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 from 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 ☐ Walking ☐ Bending ☐ Lying Down

PAST MEDICAL HISTORY

1) Have you ever been in an accident before? ☐ Yes ☐ No If yes, explain _____

2) Do you take any meds? ☐ Yes ☐ No Please list _____

3) Do you have any health problems? ☐ Yes ☐ No If yes, explain _____

4) Have you ever had surgery? ☐ Yes ☐ No If yes, Explain _____

_____

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

Patient Signature_____ Date_____