

ACCIDENT REPORT

Name _____ Date of Accident _____ Time of accident _____ am/pm

Type of injury: auto - work injury - fall - other _____

Where did accident happen, in detail _____

Did weather (ice, snow, rain or lighting, etc) play any part in accident? _____

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

<p>1) GENERAL SYMPTOMS: nervousness loss of sleep irritability tension fatigue PMS depression Jaw pain</p>	<p>7) MIDBACK: pain <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> both <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe spasm <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> both <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe</p>
<p>2) HEAD: headache: <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe how often _____ times per <input type="checkbox"/> day <input type="checkbox"/> week <input type="checkbox"/> month are they <input type="checkbox"/> sharp <input type="checkbox"/> dull <input type="checkbox"/> constant <input type="checkbox"/> intermittent where located <input type="checkbox"/> back of head <input type="checkbox"/> forehead <input type="checkbox"/> temples <input type="checkbox"/> right side <input type="checkbox"/> left side <input type="checkbox"/> behind eyes Light headed Sensitivity to light memory loss loss of balance blurred vision hearing loss double vision ringing in ears</p>	<p>8) CHEST: chest pain <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> both <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe rib pain <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> both shortness of breath irregular heartbeat</p>
<p>3) NECK: pain: <input type="checkbox"/> left side <input type="checkbox"/> right side <input type="checkbox"/> both <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe increased by: forward movement backward movement rotation of head (right/left) bending of neck (right/left) stiffness muscle spasm grinding/grating sounds</p>	<p>9) ABDOMINAL SYMPTOMS: pain <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> both nervous stomach nausea gas constipation diarrhea heartburn indigestion loss of appetite</p>
<p>4) SHOULDERS: pain in joint <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> both pain across shoulder <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> both limitation of movement <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> both tension <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> both</p>	<p>10) LOWBACK: pain <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> both spasm <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> both</p>
<p>5) ARMS upper arm pain <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> both pins & needles <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> both numbness <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> both elbow pain <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> both forearm pain <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> both pins & needles <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> both numbness <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> both</p>	<p>11) HIPS AND LEGS: pain in buttocks <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> both <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe pain in hip(s) <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> both <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe pain down leg(s) <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> both <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe knee pain <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> both <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe leg cramp <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> both</p>
<p>6) HANDS: wrist pain <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> both hand pain <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> both pins & needles <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> both numbness <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> both</p>	<p>12) FEET: ankle pain/swelling <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> both foot pain/cramps/ numbness/swelling <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> both</p>

Are your symptoms (1) getting worse, (2) improving, (3) same?

Have you seen another doctor for these symptoms? _____ If so, name and address _____ phone _____

Did you have any of these symptoms prior to this injury? _____ If so, please explain _____

Have you had previous injury to the presently injured area? _____ If yes, when _____

Describe previous injury _____

Doctor consulted _____

Time missed from work for previous injury _____

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? _____

Are you right or left handed (circle one)? If married, is your spouse employed? Yes / no

If the present injury was due to an **auto accident**, were you the driver, passenger front, passenger back, or pedestrian?

other _____

Were you wearing seatbelt?

Type of vehicle: auto, truck, van, motorcycle, motorhome, bicycle (other _____)

How accident occurred: A) struck by another vehicle B) struck another vehicle C) struck a stationary object

D) other _____

Where was your vehicle hit? A) front B) rear C) rt side D) lft side E) right front F) lft front G) right rear H) left rear

Your approximate speed _____ MPH Other vehicle's approximate speed _____ MPH

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

tensed body for impact	neck whipped forward & back	spine torqued and twisted	thrown over seat
thrown from vehicle	pinned in vehicle	thrown from side to side	cut and bruised

Did you strike your ...

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

shoulder lft/rt (dash, windshield, steering wheel, right door, left door, seat frame, other)

arm lft/rt (dash, windshield, steering wheel, right door, left door, seat frame, other)

elbow lft/rt (dash, windshield, steering wheel, right door, left door, seat frame, other)

wrist lft/rt (dash, windshield, steering wheel, right door, left door, seat frame, other)

hip lft/rt (dash, windshield, steering wheel, right door, left door, seat frame, other)

knee lft/rt (dash, windshield, steering wheel, right door, left door, seat frame, other)

ankle lft/rt (dash, windshield, steering wheel, right door, left door, seat frame, other)

Where you rendered unconscious? Yes/no Did you receive medical attention at scene? _____

Where did you go immediately following accident? Hospital - home - doctor - this office - resumed regular activities

Comments

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

Signature _____

Date _____