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AUTOMOBILE ACCIDENT REPORT

NAME_____ DATE_____

HISTORY OF OCCURRENCE

Date of Accident: _____ Time: _____ ☐ AM ☐ PM

Driver of car: _____ Where were you seated? _____

Who owns the car? _____ Year and model of car? _____

What was the approximate damage done to the car you were in? $_____

Visibility at time of accident: ☐ Poor ☐ Fair ☐ Good

Road conditions at time of accident: ☐ Icy ☐ Rainy and ☐ Wet ☐ Clear ☐ Dark

Your car: ☐ Hit another car ☐ Was hit in the: ☐ Right ☐ Left ☐ Rear ☐ Front ☐ Side

Type of accident: ☐ Head-on collision ☐ Broad side collision

☐ Rear-end collision ☐ Front impact, rear-ended car in front

☐ Non-collision: _____

Describe in your own words what happened to you upon impact: _____

_____

Did you see the accident coming: ☐ Yes ☐ No

Were you forewarned that the accident was about to happen? ☐ Yes ☐ No

Did you brace for the impact: ☐ Yes ☐ No

Were seat belts worn? ☐ Yes ☐ No

Were shoulder harnesses worn? ☐ 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?

The top of headrest was even with: ☐ the bottom of the head ☐ the top of the head ☐ the middle of the neck

Was your car braking? ☐ Yes ☐ No

Was your car moving at the time of accident? ☐ Yes ☐ No

If yes, how fast would you estimate you were going? _____ MPH (estimate)

How fast was the other car travelling? _____MPH (estimate)

☐ Head looking straight forward ☐ Head looking back ☐ Head turned: ☐ Right ☐ Left

☐ Body straight in sitting position ☐ Body rotated: ☐ Right ☐ Left

At the time of accident, recall what parts of your head or body hit what parts on the inside of your car: _____

_____

As a result of the accident you were: ☐ Unconscious ☐ Dazed, circumstances vague ☐ Shaken up but could function

Could you move all parts of your body? ☐ Yes ☐ No

In no, what parts and why? _____

Were you able to get out of the car and walk unaided? ☐ Yes ☐ No

If no, why not? _____

WORK STATUS HISTORY

Occupation: _____ Employer: _____

Have you missed time from work? ☐ Yes ☐ No

If yes: Full-time off work _____ to _____

Part-time off work _____ to _____

☐ I have been unable to work since the accident.

FIRST DOCTOR/HOSPITAL/CLINIC SEEN

Did you go to seek medical help immediately/soon after the accident? ☐ Yes ☐ No

If yes, how did you get there? ☐ Someone else drove me ☐ Drove own car ☐ Ambulance ☐ Police

DOCTOR/HOSPITAL/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, what treatment was given to you? _____

What benefits did you receive from the treatment? _____

Date of last treatment by that facility: _____

PRIOR SIMILAR SYMPTOMS

Did you have any physical complaints just before the accident? ☐ Yes ☐ No

If yes, please describe in detail: _____

Prior to this accident, have you **EVER** had symptoms similar to what you're experiencing now? ☐ Yes ☐ No

If yes, please explain (briefly include past falls, injuries, accidents, operations, etc.): _____

_____

PAIN LEVEL/SCALE OF RECOVERY

On a scale of 0-10, with 0 being (examiner's quote), "You're pain free and can function quite well," and 10 being, "You're in pain all the time and cannot function at all," where would you rate yourself?

NORMAL	LOW PAIN	MODERATE PAIN	INTENSE PAIN	EMERGENCY
0	1 2 3	4 5 6	7 8 9	10

Please explain why: _____

Relative to where you were before this injury, how would you rate how much you have recovered so far? _____%

ATTORNEY ON CASE

Do you have an attorney on this case? ☐ Yes ☐ No If yes, who?

Name: _____

Address: _____

City/State/Zip: _____

CHANGES IN PATIENT'S LIFESTYLE SINCE THE INJURY

FUNCTIONAL: (Please mark all the items which are difficult or painful)

□ Washing or showering
□ Eating/Eating movements
□ Arising out of bed
□ Dressing yourself, putting on shoes
□ Brushing teeth, shaving, applying makeup
□ Driving, opening car doors, steering, etc.
□ Getting in or out of car/truck
□ Performing other household chores
□ Other: _____

_____

FAMILY/SOCIAL:

□ Any athletic activities
□ Cooking meals
□ Washing dishes/Clothes
□ Pushing lawn mower, yard work
□ Picking up children
□ Changing diapers
□ Taking out the trash
□ Sexual relations
□ Shopping – Groceries, clothing, etc.
□ Vacuuming carpets
□ Sweeping, mopping floors
□ Other: _____

_____

AUTOMOBILE ACCIDENT – INSURANCE DATA

Patient's Insurance Company Information

Company Name: _____ Phone #: _____

Address: _____

City/State/Zip: _____

Policy #: _____ Group #: _____

Agent/Adjustor's Name: _____

Other Driver's Insurance Information

Other Driver's Name (if another car was involved): _____ Phone #: _____

Company Name: _____ Phone #: _____

Address: _____

City/State/Zip: _____

Policy #: _____ Group #: _____

Agent/Adjustor's Name: _____

Patient's Signature: _____ **Date**: _____