# ACCIDENT/INJURY REPORT

Name:_____ Date of Accident _____

Location of accident:_____ Time:_____ am / pm

Describe how the accident happened in your own words: _____

_____

_____

Were you unconscious? ❍ No ❍ Yes / How long? _____ In a Daze ❍ No ❍ Yes

Please describe how you felt immediately after the accident: _____

_____

Have you gone to the hospital or seen any other doctor? ❍ No ❍ Yes / How did you get their? ❍ Ambulance ❍ Private Transportation

Were you placed in: ❍ Neck collar ❍ Splints ❍ Brace

When did you go? ❍ Just after accident ❍ The next day ❍ Other:_____

Name of Hospital:_____ Name of attending doctor: _____

How long did you stay:_____ Were X-rays taken? ❍ No ❍ Yes

What was the diagnosis?_____ What treatment did you receive?_____

What recommendations were made?_____

Have you been able to work since this injury? ❍ Yes ❍ No Are your work activities restricted? ❍ Yes ❍ No

Is your condition getting worse? ❍ Yes ❍ No ❍ Constant ❍ Comes and Goes

Was the accident reported? ❍ No ❍ Police ❍ Employer/Supervisor

**Indicate ✓ the symptoms that are a result of this injury:**

| | | | |
|---|---|---|---|
| ❍ Dizziness | ❍ Difficulty sleeping | ❍ Jaw problems | ❍ Nausea |
| ❍ Memory loss | ❍ Irritability | ❍ Arm/shoulder pain | ❍ Back pain |
| ❍ Headache(s) | ❍ Fatigue | ❍ Numb hands/fingers | ❍ Lower back pain |
| ❍ Blurred vision | ❍ Tension | ❍ Chest pain | ❍ Back stiffness |
| ❍ Buzzing in ear | ❍ Neck pain | ❍ Shortness of breath | ❍ Leg pain |
| ❍ Ears ringing | ❍ Neck stiff | ❍ Stomach upset | ❍ Numb feet/toes |

❍ Other: _____

**Turn form over and complete according to type of accident you were in.**

## TRAFFIC / AUTO ACCIDENT

Were you the : ❍ Driver ❍ Front passenger ❍ Rear passenger ❍ Pedestrian Number of people in vehicle: _____
Was a traffic citation issued? ❍ No ❍ Yes / to whom ❍ You ❍ Driver of your vehicle ❍ Driver of other vehicle
Did the police come to the accident site?... ❍ No ❍ Yes Were their any witnesses? ❍ No ❍ Yes
Were you wearing your seat belt?..... ❍ No ❍ Yes Does it have a shoulder harness? ❍No ❍ Yes
Was this vehicle equipped with an air bag? ❍No ❍ Yes Did it inflate? ❍No ❍Yes
In relation to the base of your skull, where was the headrest? ❍ Above ❍ Below ❍ At the base of skull
What did your vehicle impact? ❍ Another vehicle ❍ Other _____
Make and model of vehicle you were occupying: _____ Year _____
Make and model of other vehicle involved: _____ Year _____
At the time of impact your vehicle was: ❍ Slowing down ❍ Stopped ❍ Gaining speed ❍ Moving at steady speed
At the time of impact the other vehicle was: ❍ Slowing down ❍ Stopped ❍ Gaining speed ❍ Moving at steady speed
Estimated speeds at the time of crash: Your vehicle: _____mph Other vehicle: _____mph
Did any part of your body strike anything in the vehicle? ❍No ❍ Yes
If yes please explain: _____
_____
Did the impact to your vehicle come from the: ❍ Front ❍ Rear ❍ Right side ❍ Left side ❍ Other:_____
During impact were you facing ❍ Right ❍ Left ❍ Forward ❍ Looking in rear view mirror
Were you: ❍ Aware of the collision ❍ Surprised If Aware were you: ❍ Relaxed ❍ Bracing yourself for the impact
Were you holding on to the steering wheel at the time of impact? ❍ Yes ❍ No
Have you been in contact with your auto insurance company? ❍ No ❍ Yes / Date:_____

## WORK / ON THE JOB INJURY

Was your accident directly related to your work? ❍ Yes ❍ No What is your job title: _____
List any equipment, machinery and/or object related to accident:_____
Type of work being done at the time of injury: _____
Has a worker comp claim been filed? ❍ No ❍ Yes / date _____
Give the address where the accident occurred: (if other than that of employer)_____
What recommendations did your employer make just after your accident?_____
Has this type of accident happened to you before? ❍ Yes ❍ No How long have been employed there:_____
To the best of your knowledge has this type of accident occurred in your workplace before? ❍ Yes ❍ No

## RECOVERY/JOB ASSESSMENT

**To evaluate the effect that continuing work will have on your recovery please complete the following:**

How many hours are in a normal work day?_____
Please ✓ indicate your daily job duties and any activities which you are occasionally asked to perform:

❍ Standing ❍ Driving ❍ Operating equipment
❍ Sitting ❍ Twisting ❍ Work with arms above head
❍ Walking ❍ Crawling ❍ Typing
❍ Lifting ❍ Bending ❍ Stooping
❍ Other : _____

## ADDITIONAL INSURANCE

**2nd Insurance Source or Auto Insurance**

Type of Insurance:_____
Co. Name:_____
Agent's Name:_____
Phone # ( )_____
Insured's name:_____
Policy # : _____
Claim # : _____
Agent's Name: _____

Patient Signature_____ Date ____/____/_____