Patient's Report of Accident

Name: ____ Date: ___________________

Accident Location: ___________________________________ City: ____________________

Date of Accident: ________________ Time: ___________ Was a police report made? ____

Were you: ☐ Driver
☐ Passenger: ☐ Front Seat ☐ Back Seat

Were you wearing seatbelts?____ ☐ Lap ☐ Shoulder

Were you struck from: ☐ Behind ☐ Right Side ☐ Left Side ☐ Front

Were you? ☐ Parked ☐ Moving Approximate speed of your car: ______ Other car: ______

Make/Type of car You were in:____________________________ Make/Type of other car: _________________________

How did the accident occur?

____

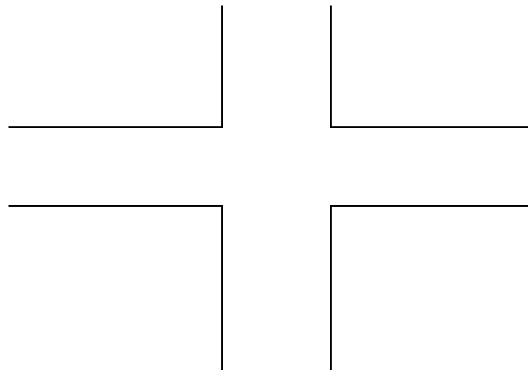
____

____

____

____

Indicate on the diagram what happened: *Indicate North by Arrow*



How did you feel immediately after the accident? If the injury was not noticeable right away, when did you notice any problems? ____

____

Have you received any first aid or other treatment for this injury?

____

Were you hospitalized? __________ If yes, how long? __________ Hospital: _________________

List any physicians, chiropractors, or physiotherapists you have seen:

Name:________________________________ City: _____________________
Name:________________________________ City: _____________________
Name:________________________________ City: _____________________

Were you off work because of this injury: ____________ If yes, the first day you were unable to work: ____________

Have you returned to work? ________ If yes, what date? __________________

List the extent of injuries as you know them: ____
____
____

Did any part of your body hit the car? Yes No Describe: _________________
____

Were you knocked unconscious? Yes No How long? _______________

Check symptoms you have noticed since the accident:

☐ Headache	☐ Dizziness	☐ Depression	☐ Fatigue
☐ Stomach upset	☐ Light bothers eyes	☐ Buzzing in ears	☐ Diarrhea
☐ Neck pain	☐ Head seems too heavy	☐ Loss of memory	☐ Feet cold
☐ Neck stiff	☐ Pins & needles in arms	☐ Ears ring	☐ Hands cold
☐ Fainting	☐ Sleeping problems	☐ Loss of balance	☐ Back pain
☐ Face flushed	☐ Pins & needles in legs	☐ Constipation	☐ Tension
☐ Nervousness	☐ Numbness in fingers	☐ Loss of smell	☐ Fever
☐ Irritability	☐ Numbness in toes	☐ Loss of taste	☐ Chest pain
☐ Cold sweats	☐ Shortness of Breath		

Symptoms other than above:____
____

Insurance Companies involved:

My Company: ____

Company of Person responsible for injuries: ____

Have you been contacted by an insurance adjuster or company representative regarding this claim? Yes No

Do you have an attorney that has advised you in this case? Yes No
Name: ____
Address: ____
Phones:____