ACCIDENTAL INJURY REPORT

If your clinic visit is due to an accident, please describe all events associated with it.

Patient Name: _____Date of accident_____ Time of accident_____ AM/PM
Type of accident ____ traffic ____ other Number of days missed from work due to accident_____

TRAFFIC ACCIDENT

Make and model of your vehicle _____Were you the _____driver _____passenger _____ pedestrian
Make and model of other vehicle_____ Your head position at time of impact _____
Your seat position in the vehicle _____ Were you wearing a seatbelt? Y/N
Was your vehicle moving when the accident occurred? Y/N MPH? _____ Did your seat break? Y/N
Visibility: ____ Good ____Poor (dark/foggy) Weather: ____Dry ____Wet Were items thrown inside the vehicle? Y/N
Did any part of your body strike the inside of the vehicle? Y/N What part? _____
Did your vehicle hit other vehicle(s) Y/N Where? _____ Did your airbags deploy Y/N
Did other vehicle(s) hit your vehicle? Y/N Where? _____
Was accident reported to police department Y/N in what city? _____
Were traffic citations issued? Y/N to whom? _____
Describe accident including cause(s) and surrounding circumstances in detail. _____
_____
_____
_____

PRESENT COMPLAINT

____ Anxiety	**_____ Chest pain**	**_____Pain behind eyes**	**_____ Equilibrium problems**
____ Tension	**_____ Irritability**	**_____ Feet/ hands cold**	**_____ Head seems too heavy**
____ Neuritis	**_____Palpitations**	**_____ Nausea, vomiting**	**_____ Extreme nervousness**
____ Fainting	**_____ Depression**	**_____ Extreme Fatigue**	**_____ Swollen _____**
____ Insomnia	**_____ Constipation**	**_____ Mental dullness**	**_____ Eyes sensitive to light**
____ Tremors	**_____ Loss of taste**	**_____ Eye loss of focus**	**_____ Mid back pain/stiffness**
____ Dizziness	**_____ Loss of smell**	**_____ Digestive disorders**	**_____ Low back pain/stiffness**
____Diarrhea	**_____ Face Flushed**	**_____ Excess perspiration**	**_____ Upper back pain/ stiffness**
____ Neck pain	**_____ Double vision**	**_____ Shortness of breath**	**_____ Pins & needles in arms/legs**
____Headaches	**_____ Sinus trouble**	**_____Ears buzzing/ ringing**	**_____ Head & shoulders tired & heavy**
____ Face pale	**_____ Neck stiffness**	**_____ Eye Strain**	**_____ Numbness in fingers, arms, legs**
____ Loss of memory		**_____Neck motion restricted**	**_____Difficulty in prolonged car riding**

____Difficulty in excessive _____ standing _____ walking _____ riding ____bending
____ Neck, low back pain & stiffness upon rising
____ Pain radiating into ____ Right arm ____ Right Leg ____ Both _____Left Arm _____ Both
____ Difficulty in excessive lifting ____ Light ____Moderate _____Heavy ____Repetitive
____ Pain radiating into ____ Neck ____Base of Skull _____Shoulders ____ Arms ___Hips ___Legs

Did you require post-accident hospitalization? ____ yes ____ no If so, where? _____
Were EMT's on the scene? _____ Were you driven _____ or taken by ambulance_____?
What treatment did you receive? _____
Have you had similar accidents or injuries before? ____yes ____ no Symptoms other than above _____

INSURANCE COMPANIES INVOLVED

Insurance company of party responsible for payment _____ Claim # _____
Have you been contacted by an insurance adjuster or company representative about claim? _____
Has your attorney advised you in this case? ____yes ____ no Attorneys name _____
Attorney's address _____ State ____ Zip _____ Phone #_____
Patient Signature _____ Date _____