Phone Number:

Accident Information

Date and time of accident: _____ First Name: _____ Last Name: _____

Name of the location/street on which you were traveling: _____

Where you the: ◯ Driver ◯ Front Passenger ◯ Rear Passenger Make and model of the vehicle you were occupying: _____

Was this vehicle equipped with airbags? ◯ Yes ◯ No Did the airbags inflate? ◯ Yes ◯ No Were you wearing a seat belt? ◯ Yes ◯ No

Did the impact to you vehicle come from the: ◯ Front ◯ Rear ◯ Right side ◯ Left side ◯ Other

In relation to the base of your skull, where was the headset? ◯ Above ◯ Below ◯ At the base

In which direction were you headed? ◯ North ◯ South ◯ East ◯ West

Direction the other vehicle was headed? ◯ North ◯ South ◯ East ◯ West

During impact, were you facing: ◯ Forward ◯ Right ◯ Left

Did any part of your body strike anything in the vehicle? ◯ Yes ◯ No

Explain:

_____

Did the accident render you unconscious? ◯ Yes ◯ No If yes, for how long? _____

What was the approximate speed of the your vehicle? _____ the OTHER vehicle? _____

Were you ◯ Aware ◯ Surprised by the impact

What did your vehicle impact? ◯ A Vehicle ◯ Other

If other, please explain below:

Number of people in the accident vehicle: _____

Please list the names of the victims in this accident:

If your own words, please describe the accident:

Please describe how you felt immediately after the accident:

Patient Social

Alcohol:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never	Caffeine:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never
Diet Food Products:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never	Drugs:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never
OTC Stimulants:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never	Exercise:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never
Homemade Food:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never	Processed Food:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never
Soft Drinks:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never	Tobacco:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never
Water:	◯ Daily	◯ Weekly	◯ Occasion	◯ Never					

Health Checklist

☐ Allergies	☐ Alcoholism	☐ Anemia
☐ Arteriosclerosis	☐ Arthritis	☐ Asthma
☐ Back Pain	☐ Breast Lump	☐ Bronchitis
☐ Bruise Easily	☐ Cancer	☐ Chest Pain
☐ Cold Extremities	☐ Constipation	☐ Cramps
☐ Depression	☐ Diabetes	☐ Digestion Problems
☐ Dizziness	☐ Excessive Menstruation	☐ Eye Pain or Difficulties
☐ Fatigue	☐ Frequent Urination	☐ Headache
☐ Hemorrhoids	☐ High Blood Pressure	☐ Hot Flashes
☐ Irregular Heart Beat	☐ Irregular Menstrual Cycle	☐ Kidney Infection
☐ Kidney Stones	☐ Loss of Memory	☐ Loss of Balance
☐ Loss of Smell	☐ Loss of Taste	☐ Nosebleeds
☐ Pacemaker	☐ Polio	☐ Poor Posture
☐ Prostate Trouble	☐ Sciatica	☐ Shortness of Breath
☐ Spinal Curvatures	☐ Sinus Infection	☐ Insomnia
☐ Swollen Joints	☐ Stroke	☐ Swelling of Ankles
☐ Ulcers	☐ Thyroid Condition	☐ Tuberculosis
	☐ Varicose Veins	☐ Venereal Disease

☐ Other: _____

Patient Signature: _____ Date: _____

Legal Information

Did the police come to the accident scene? ◯Yes ◯No Was a police report filed? ◯Yes ◯No

Were there any witnesses? ◯Yes ◯No

Was a traffic violation issued? ◯Yes ◯No

To whom:

Have you retained an attorney? ◯Yes ◯No If yes, whom? _____ Phone: _____

Medical Information

Have you gone to a hospital or seen any other doctor? ◯Yes ◯No When did you go? ◯Immediately ◯Next Day ◯2 Days Plus

How did you get there? ◯Ambulance ◯Private Transportation Was medication prescribed? ◯Yes ◯No

Name of the hospital and/or attending doctor: _____

Was he / she a: ◯D.D.S ◯M.D. ◯D.C. ◯ D.O. Were any X-rays taken? ◯Yes ◯No

Have you been able to work since this injury? ◯Yes ◯No Are you work activities restricted as a result of this injury? ◯Yes ◯No