ACCIDENT REPORT

Name:_____Date of Accident:_____Time or accident_____am/pm
Type of injury: auto - work injury - fall - other_____
Where did accident happen, in detail_____

_____

Did weather (ice, snow, rain, or lighting, etc) play any part in accident?_____
Describe your symptoms in detail: (Circle or check all that apply)

1) GERNERAL SYMPOTOMS:
nervousness, loss of sleep, irritability, tension, fatigue, PMS, depression, Jaw pain

2) HEAD:
Headache: ☐mild ☐moderate ☐severe
How often___time per ☐day ☐week ☐month
are they ☐sharp ☐dull ☐constant ☐intermittent
where located ☐back of head ☐forehead ☐temples ☐right side ☐left side ☐behind eyes
light headed, sensitivity to light, memory loss, loss of balance, blurred vision, hearing loss, double vision, ringing in ears

3) NECK:
pain: ☐left side ☐right side ☐both ☐mild ☐moderate ☐severe
increased by: forward movement, backward movement, rotation of head (right/left), bending of neck (right/left)
stiffness, muscle spasm, grinding/grating sounds

4) SHOULDERS:
Pain in joint ☐left ☐right ☐both
Pain across shoulders ☐left ☐right ☐both
Limitation of movement ☐left ☐right ☐both
tension ☐left ☐right ☐both

5) ARMS:
Upper arm
Pain ☐left ☐right ☐both
pins & needles ☐left ☐right ☐both
numbness ☐left ☐right ☐both
elbow pain ☐left ☐right ☐both
Forearm
pain ☐left ☐right ☐both
pins & needles ☐left ☐right ☐both
numbness ☐left ☐right ☐both

6) HANDS:
wrist pain ☐left ☐right ☐both
hand
pain ☐left ☐right ☐both
pins & needles ☐left ☐right ☐both
numbness ☐left ☐right ☐both

7) MIDBACK:
pain: ☐left ☐right ☐both ☐mild ☐moderate ☐severe
spasms: ☐left ☐right ☐both ☐mild ☐moderate ☐severe

8) CHEST:
chest pain ☐left ☐right ☐both ☐mild ☐moderate ☐severe
rib pain ☐left ☐right ☐both
shortness of breath
irregular heartbeat

9) ABDOMINAL SYMPTOMS:
Pain ☐left ☐right ☐both
nervous stomach, nausea, gas, constipation, diarrhea, heart burn, indigestion, loss of appetite

10) LOWBACK:
pain ☐left ☐right ☐both
spasms ☐left ☐right ☐both

11) HIPS AND LEGS:
pain in buttocks ☐left ☐right ☐both ☐mild ☐moderate ☐severe
pain in hip(s) ☐left ☐right ☐both ☐mild ☐moderate ☐severe
pain down the leg(s) ☐left ☐right ☐both ☐mild ☐moderate ☐severe
knee pain ☐left ☐right ☐both ☐mild ☐moderate ☐severe
leg cramp ☐left ☐right ☐both ☐mild ☐moderate ☐severe

12) FEET:
ankle pain/swelling ☐left ☐right ☐both
foot pain/cramps/ numbness/swelling ☐left ☐right ☐both

Are your symptoms (1) getting worse, (2) improving, (3) same?
Have you seen another doctor for these symptoms?_____ If so, name and address_____

_____

Did you have any of these symptoms prior to this injury____ If so, please explain_____

_____

Have you had previous injury to the currently injured area?_____ If yes, when_____

Describe previous injury_____

_____ Doctor consulted_____

Time missed from work for pervious injury_____

For present injury, have you missed any work?_____ If yes, dates missed_____

Dates of limited work_____Dates returned to full work_____

Were you capable of working on an equal basis prior to this present injury?_____

Are you right or left handed (circle one)? If married, is your spouse employed? yes/no

If the present injury was due to an auto accident, were you the driver, passenger front, passenger back, or pedestrian?

Other_____

Where you wearing a seatbelt?

Type of vehicle: auto, truck, van motorcycle, motoerhome, bicycle (other_____)

How accident occurred: front/rear/right side/left side/right front/left front/right rear/left rear

Your approximate speed _____MPH Other vehicle's approximate speed_____MPH

What occurred at the moment of impact? (circle as many as apply)

tensed body impact	neck whipped forward & back	spine torqued and twisted	thrown over seat
thrown from vehicle	pinned in vehicle	thrown from side to side	cut and bruised

Did you strike your…..

head	(against dash, windshield, steering wheel, right door, left door, seat frame, other)
shoulder	left/right (dash, windshield, steering wheel, right door, left door, seat frame, other)
arm	left/right (dash, windshield, steering wheel, right door, left door, seat frame, other)
elbow	left/right (dash, windshield, steering wheel, right door, left door, seat frame, other)
wrist	left/right (dash, windshield, steering wheel, right door, left door, seat frame, other)
hip	left/right (dash, windshield, steering wheel, right door, left door, seat frame, other)
knee	left/right (dash, windshield, steering wheel, right door, left door, seat frame, other)
ankle	left/right (dash, windshield, steering wheel, right door, left door, seat frame, other)

Were you rendered unconscious? yes/no Did you receive medical attention at scene?_____

Where did you go immediately following accident? hospital - home - doctor - this office - resumed regular activities

Comments

_____

_____

_____

By signing below, I acknowledge that the information given above is true to the best of my knowledge.

_____ _____

Signature Date