Accident Information:

Date: _____________ Time: _________ **AM PM**   Was it reported to the police? **YES NO**

Was a traffic violation issued? **YES NO**   To whom: ______________________________

Location of accident (Street, Town)_______________________________ # of other passengers_____________

Were there other witnesses? **YES NO**

Make/model of vehicle you were in____

Please explain in detail how the accident occurred: ____

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Please list symptoms felt immediately after the accident: ____

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In which direction were you headed? **N S E W**   Approx. speed of vehicle ___________MPH

Did the impact to your vehicle come from the: **FRONT REAR RIGHT LEFT OTHER**

During impact, were you facing: **RIGHT LEFT FORWARD**

Were you AWARE or SURPRISED by the impact?

Were you the **DRIVER FRONT SEAT PASSENGER BACK SEAT PASSENGER?**

Were you wearing a seat belt? **SHOULDER HARNESS LAP HARNESS**

Was the vehicle equipped with air bags? **YES NO**   Did they inflate? **YES NO**

In relation to the base of your skull, where was the headrest? **ABOVE BELOW AT BASE**

What did your vehicle impact? **ANOTHER VEHICLE OTHER:** ____________________________

If another vehicle, what was the make/model?________________Direction____________ Speed _____MPH

Did any part of your body strike anything in the vehicle? **YES NO**

Describe: ____

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Did the accident render you unconscious? **YES NO**   If yes, for how long?____________________

Post-Injury Information:

Have you seen any other doctor(s) since the accident? **YES** **NO**

When did you go? **IMMEDIATELY** **NEXT DAY** **2 DAYS PLUS**

How did you get there? **AMBULANCE** **PRIVATE TRANSPORTATION**

Name of hospital and/or attending doctor(s): ______________________________

______________________________ Was he/she a: **D.C.** **M.D.** **D.O.** **D.D.S.**

Please describe any treatment you received: ______________________________

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Were X-Rays done? **YES** **NO** An MRI? **YES** **NO** CAT scan? **YES** **NO**

Was medication prescribed? **YES** **NO** If yes, what? ______________________________

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Have you missed any work since the accident? **YES** **NO** Date(s): ______________________________

Are your work activities restricted as a result of your injury? **YES** **NO**

Indicate the symptoms that are a result of this accident:

DIZZINESS	**DIFFICULTYSLEEPING**	**JAWPROBLEMS**
NAUSEA	**MEMORY LOSS**	**ARM/SHOULDER PAIN**
IRRITABILITY	**BACK PAIN**	**HEADACHE(S)**
NUMB HANDS/FINGERS	**FATIGUE**	**LOW BACK PAIN**
BLURRED VISION	**TENSION**	**CHEST PAIN**
BACK STIFFNESS	**BUZZING IN EAR**	**NECK PAIN**
SHORT BREATH	**LEG PAIN**	**EARS RINGING**
NECK STIFF	**STOMACH UPSET**	**NUMB FEET/TOES**

OTHER: ______________________________

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Did you ever experience similar symptoms prior to the accident? **YES** **NO**

Has your condition **IMPROVED** **WORSENED** **STAYED SAME** since the accident?

Is your condition affecting your **WORK** **SLEEP** **DAILY ROUTINE**?

Please explain: ______________________________

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