

# Accident Information Form

Is condition due to an accident?  Yes  No Date \_\_\_\_\_

Type of accident  Auto  Work  Home  Other

To whom have you made a report of your accident?  
 Auto Insurance  Employer  Workers' Comp  Other

Attorney name (if applicable) \_\_\_\_\_

## Auto Accident Information:

Time and Date of Present Injury \_\_\_\_\_

Location of Accident

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Estimated speed of your vehicle \_\_\_\_\_ Estimated speed of other vehicle \_\_\_\_\_

At the time of impact, was the position of your head:

Straight  Turned Left  Turned Right

Were you knocked unconscious?  Yes  No If so, how long? \_\_\_\_\_

You were struck from  Behind  Front  Left side  Right side

You were  Driver  Passenger  Front Seat  Back Seat

You were using  Seat belts  Other protective devices

If applicable, indicate any pains or abnormal sensations experienced, immediately following the accident:

<input type="checkbox"/> Felt no immediate pain	<input type="checkbox"/> Pain began several hours <input type="checkbox"/> days <input type="checkbox"/> weeks <input type="checkbox"/> after accident
<input type="checkbox"/> Headache	<input type="checkbox"/> Saw stars
<input type="checkbox"/> Semi-conscious state	<input type="checkbox"/> Neck pain (R <input type="checkbox"/> L <input type="checkbox"/> )
<input type="checkbox"/> Mid back pain (R <input type="checkbox"/> L <input type="checkbox"/> )	<input type="checkbox"/> Low back pain (R <input type="checkbox"/> L <input type="checkbox"/> )
<input type="checkbox"/> Upper extremity pain (R <input type="checkbox"/> L <input type="checkbox"/> )	<input type="checkbox"/> Lower extremity pain (R <input type="checkbox"/> L <input type="checkbox"/> )
<input type="checkbox"/> Other	

## Diagnosis & Treatment After Accident:

Indicate which procedures were performed while at hospital (including emergency room)

X-Rays  Surgery  MRI  Other \_\_\_\_\_

Where were you taken after the accident? \_\_\_\_\_

What treatment was given? \_\_\_\_\_

Was any other doctor consulted after your accident?  Yes  No

What was the doctor's name? \_\_\_\_\_  D.C.  M.D.  D.O.  D.D.S.  P.T.

What procedures were done? \_\_\_\_\_

What was the diagnosis? \_\_\_\_\_

What treatment was given? \_\_\_\_\_

How often did you see the doctor/therapist? \_\_\_\_\_

How long did you see the doctor/therapist? \_\_\_\_\_

Have you ever had any complaints in the involved area before?  Yes  No

If so, what were the complaints? \_\_\_\_\_

Before the injury, were you capable of working on an equal basis with others your age?  Yes  No

Are your work activities restricted as a result of this accident?  Yes  No

Have you lost time from work as a result of this accident?  Yes  No

If Yes, please complete:

Place and type of employment \_\_\_\_\_

Since this injury, are your symptoms  improving?  getting worse?  the same?

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

If patient is under 18:

Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_