PERSONAL INJURY ACCIDENT INFORMATION

Patient Name:_____ Account Number:_____

1. Date of Accident:_____ Time of Day:_____
2. Were you: ☐ Driver ☐ Passenger ☐ Front Seat ☐ Back Seat
3. Number of people in your vehicle?_____ Other vehicle?_____
4. What direction were you headed? ☐ North ☐ South ☐ East ☐ West

   Name of the street:_____ Name of county_____
5. What direction was the other vehicle headed? ☐ North ☐ South ☐ East ☐ West
6. Were you struck from: ☐ Behind ☐ Front ☐ Left Side ☐ Right Side
7. Were you knocked unconscious? ☐ Yes ☐ No
   If yes, for how long?_____
8. Were the police notified? ☐ Yes ☐ No
9. Was anyone ticketed? ☐ Yes ☐ No Who?_____
10. In your own words, please describe the accident:_____

_____

_____

11. Please describe how you felt:
    a. **during** the accident:_____
    b. **immediately after** the accident:_____
    c. **later that day:**_____
    d. the **next day:**_____
12. What are your **present** complaints and symptoms?_____
13. _____
14. Where were you taken after the accident?_____
15. Have you been treated by another Doctor since the accident? ☐ Yes ☐ No

    If yes, please list the Doctor's name and address:_____

    _____

    What type of treatment did you receive?_____

    _____
16. As a result of this accident, have you lost work time? ☐ Yes ☐ No
    If yes, please complete this question.
    a. Date last worked:_____ b. Type of employment:_____
17. Do you notice any activity restrictions as a result of this injury? ☐ Yes ☐ No
    If yes, please list any activity restrictions:_____

    _____

    _____