MOTOR VEHICLE ACCIDENT INFORMATION

Patient Name:_____

Date of Accident:_____ Time of Day:_____

Were you: ☐ Driver ☐ Passenger ☐ Front Seat ☐ Back Seat

Number of people in your vehicle: _____

Noticeable damage to **your** vehicle: ☐Yes ☐No

Noticeable damage to **their** vehicle: ☐Yes ☐No

Were you able to drive **your** vehicle after the accident: ☐Yes ☐No

Describe the damage to **your** vehicle:_____

Were you struck from: ☐Behind ☐Front ☐Left Side ☐Right Side

Were you knocked unconscious? ☐Yes ☐No

Have you had any memory issues since the accident? ☐Yes ☐No

Were the police notified? ☐Yes ☐ No Anyone ticketed? ☐Yes ☐ No If yes, Who?_____

In your own words, please describe the accident: _____

_____

What are your **present** complaints and symptoms? _____

_____

Where were you taken after the accident? _____

Have you had treatment since the accident? ☐Yes ☐No

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

What type of treatment did you receive? _____

As a result of this accident, have you lost work time? ☐ Yes ☐No

If yes, date last worked: _____

Do you notice any activity restrictions as a result of this injury? ☐Yes ☐No

If yes, please list any activity restrictions: _____

_____