Accident Report

Name________________________________ Date of accident ______________ Time_______ ☐AM ☐PM

Location of accident____ State______ Witnesses ☐Yes ☐No

Have you lost any time from work: ☐Yes ☐No Give dates: ______________________________________

Auto Accident

-Where were you sitting in the car?__________________________________ - # of people in the car: __________

-Were you wearing a seatbelt? ☐Yes ☐No -Type of seat belt were you wearing? ☐Lap Belt ☐Shoulder Harness

-Did airbags deploy at time of impact? ☐Yes ☐No -Did you lose consciousness? ☐Yes ☐No

-Did you hit any body part on the inside of any part of the car? Please Describe: ________________________________

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-Where was the head-rest of your seat: ☐Above the ears ☐At level of ears ☐Below ears

-What kind of car were you in?______________________ -What kind of car was the other car?___________________

-Where were you hit?____

-At the time of impact where were you looking? ☐Forward ☐Back ☐To the right ☐To the left ☐Up ☐Down

-Road Condition: ☐Wet ☐Dry ☐Ice ☐Snow -Was your car: ☐Stopped ☐Moving _______mph.

-Briefly describe the accident: ____

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-How much damage was done to your car, actual estimate given $____

-Did the police come to the scene of the accident? ☐Yes ☐No -Was a report filed? ☐Yes ☐No

-Was a ticket issued? ☐Yes ☐No If yes, to whom ____

Work Accident

-Please describe what happened: ____

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-Who did you report the accident to: ________________________ -Were there any witnesses? ☐Yes ☐No

-Was an accident report filed and signed by you? ☐Yes ☐No

-What recommendations did your employer make at the time of the accident? _____________________________

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-Does your employer know that you came here for an evaluation? ☐Yes ☐No

-Were you given the name(s) of any other doctor? If so, who? ____

-Did you go? If so, when? ____

-Have you had any other work-related accident? ☐Yes ☐No If yes, when? _______________________________

-Please describe: ____

-Did you go to the hospital? ☐Yes ☐No -How did you get there? ______________________________________

-When? ______________________ -Have you seen any other doctor before coming here? ☐Yes ☐No

-What other treatment have you received? ____

-Have you had any x-rays taken or other testing done? ____