

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: _____

-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: _____

-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: _____

-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? _____

-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? _____