

# 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? \_\_\_\_\_