ACCIDENT REPORT

Name _____ Phone ( ) _____
Address _____ City _____ State _____ Zip _____
Employers name _____ Address _____

Insurance Company _____ Phone ( ) _____
Address _____ City _____ State _____ Zip _____
Claim # _____ Adjuster's Name _____

Nature of Accident:

1. Date of accident: ___/___/___ Location: _____

2. Were you: ( ) Driver ( ) Passenger ( ) Front seat ( ) Back Seat

3. Number of people in vehicle _____ Were you wearing seatbelts? _____ Headrest? _____

4. Were you struck from: ( ) Behind ( ) Front ( ) L-side ( ) R-side
   How fast were you going? _____ Speed of other vehicle? _____
   Did you hit any part of the cars inside? _____

5. In your own words, please describe the accident: _____

6. Where were you taken after the accident? _____

7. Have you been treated by another doctor since the accident? _____

   What type of treatment did you receive? _____

8. Have you lost time from work as a result of the accident? _____ If yes, how long? _____

   1. Last day worked: _____
   2. Type of employment: _____

9. Did you have any physical complaints **BEFORE** the accident? _____

Check symptoms you have noticed since the accident:

___ Headache
___ Neck Pain
___ Nervousness
___ Fatigue
___ Fainting
___ Loss of Smell
___ Feet Cold
___ Stomach Upset
___ Chest Pain
___ Irritability
___ Neck Stiff
___ Tension
___ Depression
___ Diarrhea
___ Loss of Taste
___ Hands Cold
___ Loss of Memory
___ Shortness of Breath
___ Numbness in toes
___ Sleeping Problems
___ Shortness of Breath
___ Numbness in Fingers
___ Buzzing in Ears
___ Lights Bother Eyes
___ Pins & Needles in Legs
___ Pins& Needles in Arms
___ Head Seems to Heavy
___ Face Flushed
___ Back Pain
___ Dizziness
___ Ears Ring
___ Loss of Balance
___ Constipation
___ Fever
___ Cold Sweats

Other important information pertaining to the accident:_____

_____

_____

_____

_____ __/__/__

Patient Signature Date