Personal Injury Incident Report

Account # _______________

Name: ______________________________________ Date: _________________________

Address: ____

City: __________________________ State: _______ Zip: ____________________

(H): _________________________________ (W): _________________________________

Cell: ________________________________ E-mail: ______________________________

AUTO HISTORY:

Date of accident: ______________________ Time of Day: _____________
Were you the: ( ) Driver ( ) Passenger ( ) Pedestrian
Where were you? ( ) Front seat ( ) Back Seat ( ) Right side ( ) Left side
Were you wearing a seat belt? Y / N Did your vehicle have waist and shoulder restraints? Y / N
Did your vehicle have headrests? Y / N
No. of persons in your vehicle: ___________ Other vehicle: ____________
Does your vehicle have air bags? Y/ N If yes, did they deploy? Y / N
Were the police notified? Y / N Was a summons issued? Y / N
Do you have a copy of the police report? Y / N If yes, please provide our office with a copy.

How did the accident happen? ____

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Name of the streets where the accident occurred: ____

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Was your car: ( ) Stopped? ( ) Moving? If moving, how fast? _______________________________
What direction were you headed?: ( ) North ( ) South ( ) East ( ) West
Were you struck from the: ( ) Front ( ) Back ( ) Right side ( ) Left side
Did your body strike anything in the car? Y / N If yes, what? _______________________________

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Was an ambulance necessary? Y / N
Were you taken to the hospital? Y / N If yes, what hospital? _______________________________
Were x-rays taken? Y / N
What services were performed? ____

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What you prescribed any medications? Y / N If so, please indicate what medications: __________

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Were you admitted to the hospital? Y / N If yes, who was your doctor?__________________________

SYMPTOMS:

What are your present complaints/symptoms? ____

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24 hours after the accident, was the pain/complaint/symptom: ( ) Severe?( ) Moderate? ( ) Mild?

Check the following symptoms you have noticed since the accident:

( ) Headaches ( ) Neck Pain ( ) Neck stiffness ( ) Back pain ( )Tension ( ) Low back pain
( )Problems sleeping ( ) Dizziness ( ) Shortness of breath ( ) Depression ( ) Chest pain
( ) Irritability ( ) Ears ringing
Numbness of: ( ) Arms ( ) Hands ( ) Finders ( ) Legs ( ) Feet
Loss of: ( ) Smell ( ) Taste ( ) Hearing ( ) Vision ( ) Touch
( ) Other ____

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Since the accident, are your symptoms: ( ) Improving? ( ) Same? ( ) Worse
Did you suffer any: ( ) Cuts? ( ) Bleeding? ( ) Broken arms? ( ) Lacerations ( ) Bruises

How was your health at the time of the accident? ____

Restrictions as a result of the current accident:

The above descriptions/symptoms/complaints have restricted my life in the following ways:

Sitting ____

Driving ____

Standing ____

Lifting ____

Exercising ____

Employment ____

Socially ____

Loss time from work:

Type of employment: ____

Have you lost anytime from work as a result of this accident? Y / N
If yes, last day worked: ________________________________

Past History:

Have you been involved in any previous MVA's? Y / N

If yes, please list date and any impairment as a result of that accident (s): ______________________

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List any medications you are using: ____

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List any surgeries you have had: ____

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Any history of fractures? Y / N If yes, please describe: ______________________________

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Patient's Signature: ___________________________________ Date: __________________