MOTOR VEHICLE ACCIDENT FORM

Name ______________________________ Date of Accident ____________________

Number of vehicles involved ______ City / State of Accident ____________________

Describe the accident ____

____

What did the vehicle do immediately following the accident? ☐ hit a guardrail ☐ hit a tree

☐ rolled over ☐ was run off the road ☐ other ____________________

Were you the ☐ driver ☐ front passenger ☐ rear passenger

Were you surprised by impact? ☐ unaware ☐ aware but relaxed ☐ aware and braced for impact

Vehicle you were in was a ☐ small size ☐ mid size ☐ full size ☐ suv ☐ truck

Other vehicle was a ☐ small size ☐ mid size ☐ full size ☐ suv ☐ truck

Did you lose consciousness? ☐ yes ☐ no

How was your head positioned? ____________________

Did any part of your body strike anything inside the car ☐ yes ☐ no

If yes, please explain ____________________

Were you wearing a seatbelt? ☐ yes ☐ no

Which doors, if any, would not open as a result of the accident? ____________________

Check the symptoms you have experienced from the time of the accident to present

☐ chest pain	☐ ear buzzing	☐ memory loss	☐ fatigue	☐ headaches
☐ irritability	☐ jaw problems	☐ dental problems	☐ dizziness	☐ nausea

Are your symptoms worsening? ☐ yes ☐ no

Did you go to the hospital or treatment facility? ☐ yes ☐ no *(if no, go to bottom of page)*

Where ____________________

When ☐ immediately following ☐ next day ☐ 2 days or more following

How ☐ ambulance ☐ private transportation

Were you hospitalized over night? ____________________

Were you prescribed ☐ pain medication ☐ muscle relaxors ☐ neck brace

Were x-rays taken? If yes, which areas? ____________________

I Certify That The Above Information Is Correct To The Best Of My Knowledge.

Patient Signature ______________________________ Date ____________________