MOTOR VEHICLE ACCIDENT FORM

Name_____ Date of Accident_____

Number of vehicles involved_____ City / State of Accident _____

Describe the Accident_____

_____

What the vehicle do immediately following the accident_____

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

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

□ Chest pain □ Ear buzzing □ Nausea □ Fatigue □ Headaches □ Dizziness □ Irritability

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 overnight? _____

Were you prescribed □ Pain medication □ Muscle relaxers □ 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_____