

## Patient's Report of Accident

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Location of Accident: \_\_\_\_\_ City: \_\_\_\_\_

Date of Accident: \_\_\_\_\_ Time: \_\_\_\_\_ Was a police report made? \_\_\_\_\_

Were you:  Driver  Passenger:  Front Seat  Back Seat

Where you wearing seatbelts? \_\_\_\_\_  Lap  Shoulder

Were you struck from:  Behind  Right side  Left side  Front

Were you?  Parked  Moving Approximate Speed of your car: \_\_\_\_\_ Other car: \_\_\_\_\_

Make/Type of car you were in: \_\_\_\_\_ Make/Type of other car: \_\_\_\_\_

How did the accident occur?

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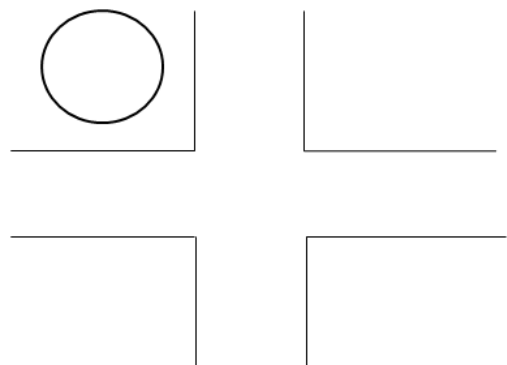
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Indicate on the diagram what happened:

*Indicate North by Arrow*



How did you feel immediately after the accident? If the injury was not noticeable right away, when did you notice any problems? \_\_\_\_\_

Have you received any first aid or other treatment for this injury?

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Were you hospitalized? \_\_\_\_\_ If yes, how long? \_\_\_\_\_ Hospital: \_\_\_\_\_

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List any physicians, chiropractors, or physiotherapists you have seen:

Name: \_\_\_\_\_ City: \_\_\_\_\_  
Name: \_\_\_\_\_ City: \_\_\_\_\_  
Name: \_\_\_\_\_ City: \_\_\_\_\_  
Name: \_\_\_\_\_ City: \_\_\_\_\_

Were you off work \_\_\_\_\_ If yes, the first day  
because of this injury? \_\_\_\_\_ you were unable to work: \_\_\_\_\_

Have you returned to work? \_\_\_\_\_ If yes, on what date? \_\_\_\_\_

List the extent of injuries as you know them: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Did any part of your body hit the car?  Yes  No Describe: \_\_\_\_\_  
\_\_\_\_\_

Were you knocked unconscious?  Yes  No How long? \_\_\_\_\_

Check symptoms you have noticed since the accident:

<input type="checkbox"/> Headache	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Depression	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Stomach upset	<input type="checkbox"/> Light bothers eyes	<input type="checkbox"/> Buzzing in ears	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Neck pain	<input type="checkbox"/> Head seems too heavy	<input type="checkbox"/> Loss of memory	<input type="checkbox"/> Feet cold
<input type="checkbox"/> Neck stiff	<input type="checkbox"/> Pins & needles in arms	<input type="checkbox"/> Ears ring	<input type="checkbox"/> Hands cold
<input type="checkbox"/> Fainting	<input type="checkbox"/> Sleeping problems	<input type="checkbox"/> Loss of balance	<input type="checkbox"/> Back Pain
<input type="checkbox"/> Face flushed	<input type="checkbox"/> Pins & needles in legs	<input type="checkbox"/> Constipation	<input type="checkbox"/> Tension
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Numbness in fingers	<input type="checkbox"/> Loss of smell	<input type="checkbox"/> Fever
<input type="checkbox"/> Irritability	<input type="checkbox"/> Numbness in toes	<input type="checkbox"/> Loss of taste	<input type="checkbox"/> Chest pain
<input type="checkbox"/> Cold sweats	<input type="checkbox"/> Shortness of breath		

Symptoms other than above: \_\_\_\_\_  
\_\_\_\_\_

**Insurance Companies Involved:**

My company: \_\_\_\_\_

Company of person responsible for injuries: \_\_\_\_\_

Have you been contacted by an insurance adjuster or company representative regarding this claim?

Yes  No

Do you have an attorney that has advised you in this case?  Yes  No

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_