Doctor's Personal Injury/Workman's Comp Accident Form

Patient's Vehicle Type: _____

Patient's Vehicle was hit by: _____

Patient's Vehicle hit: _____

Position in the Vehicle: ☐ Driver ☐ Front Mid Passenger ☐ Front right Passenger

☐ Rear left Passenger ☐ Rear right Passenger ☐ Front right Passenger

Action of the Patient's Vehicle: ☐ Stopped for pedestrian ☐ Traveling at the speed limit

☐ Crossing intersection ☐ Stopped in traffic ☐ Traveling speed limit

☐ Turning left ☐ Turning right

Damage: ☐ Complete ☐ Extensive ☐ Minimal ☐ Moderate

Damage to other Vehicle: ☐ Complete ☐ Extensive ☐ Minimal ☐ Moderate

Weather Condition's: _____

Road Condition's: _____

Time of Day: ☐ Dawn ☐ Daylight ☐ Dusk ☐ Night

Visibility: ☐ Fair ☐ Good ☐ Poor

Body Position at impact: ☐ Slouched ☐ Turned left ☐ Leaning Forward ☐ Straight ☐ Turned right

Direction body was thrown: ☐ Forward then back ☐ To the right ☐ To the left ☐ Outside vehicle

☐ Under vehicle ☐ About vehicle ☐ Backward then forward

Head Position at impact: ☐ Straight ☐ Tilted forward ☐ Turned left ☐ Turned right

Direction head was thrown: ☐ Back then forward ☐ Forward then back ☐ Side to Side

Type of Passive Restraint: ☐ Shoulder-lap belt ☐ Airbag ☐ None

Headrest Position: ☐ High ☐ Middle ☐ Low ☐ Not Installed

Did you brace for impact? ☐ Yes ☐ No

Did you go to the hospital? ☐ Yes ☐ No If yes, who took you? _____

Did you receive any cuts, bruises, or lacerations? ☐ Yes ☐No

If yes, where were the cuts, bruises or lacerations located? _____

Immediately after the accident how did you feel? _____

Were you unconscious? ☐ Yes ☐ No **Did you go to the hospital?** ☐ Yes ☐ No If yes,

Which hospital? _____

Were you x-rayed in the hospital? ☐ Yes ☐ No

Did they write you a prescription for medication? _____

Have you seen any other Doctors for this accident? _____

Have you had any diagnostic testing? MRI? CT?

How did you get to the hospital? ☐ Ambulance ☐ Family Member

Did the ambulance attendants place you in: ☐ Neck Collar ☐ Splints ☐ Brace

Have you lost time from work due to the accident? ☐ Yes ☐ No If yes, what dates? _____

Did you own the vehicle? ☐ Yes ☐ No **Do you or anyone in your household currently own a vehicle?** ☐ Yes ☐ No