AUTO ACCIDENT REPORT FORM

Name: _____ Date: _____

Address: _____

_____

FILL IN AND CIRCLE ANSWERS

HISTORY OF PRESENT SYMPTOM(S)

The above alleges (his) (her) present condition is due to (a) (an) _____accident which took place on (date) _____at approximately (time) _____(AM)(PM). The patient was (driving)(a passenger) in a (car)(truck)(other) _____and was seated (in front)(in back)(other) _____. The vehicle with the patient in it was (stopped)(traveling) on _____(highway)(route), _____(street) (Avenue)_____(city)_____(county)_____(state), (facing)(going)(east)(west)(north)(south) when another vehicle (in back)(in front)(on the right)(on the left) met in a collision. The vehicle the patient was in (was struck by) (struck) the other (car)(truck)(bus)(other) _____with the patient's vehicle sustaining damage to the (rear)(front)(right)(left)(side). At the time of the collision the patient was (looking forward-up-down-to the right-to the left) and struck (his)(her) (give body parts)_____against the (steering-wheel)(dashboard)(other) _____with a resultant (contusion)(cut)(dislocation) of the (area) _____. The patient (did)(did not) notice immediate pain in the _____region(s). The patient (was)(was not) rendered unconscious. (He)(She)(was)(was not) able to get out and walk from the vehicle unaided. The patient (was)(was not) wearing a seat belt. The patient went (home)(to the hospital)(other) _____by (own)(another)(ambulance)(police) Vehicle where (he)(she)(rested)(was examined)(other) _____. Patient (did)(did not) stay in confinement and (did)(did not) receive treatment consisting of _____. The patient spent (an)(a)(uneventful)(restless)

(painful) night and the following day felt (better)(worse)(the same) experiencing (relief) (pain)(numbness)(aching) in the _____region(s). The patient (has) (has not) missed work from(date) _____ to (date) _____ in (his) (her) job as (a)(an) _____. The patient alleges that (his) (her) present complaint(s) (has)(have) (interfered with)(lessened)(eliminated) the ability to do the following: _____.

Previous doctors seen by the patient include:

Dr._____(date)_____for_____

Dr._____(date)_____for_____

Dr._____(date)_____for_____

From the time of the accident, have there been any of the following? If so, please explain in the spaces provided below. Eye complaints _____ Ear complaints _____ Facial Disturbances _____ Difficulty in swallowing_____ Dizziness_____ Increased Sweating_____ Nasal disturbances_____ Chest pain or disturbance_____ Lapse of consciousness_____ Headaches_____ Insomnia_____ Restlessness_____ Mood changes_____ Behavior changes_____ Numbness of extremities_____ Tingling of the arms or legs_____ Coldness of the hands or feet_____ Inability to urinate_____ Difficulty in urinating_____ Loss of strength in the arms or legs_____ Difficulty in moving the arms or legs_____ Clumsiness_____

Please Explain any of the above:

_____

_____

_____

Other Symptoms?

_____

_____

Please Sign: ____