Vehicle Accident Information

Absolute Wellness, PLLC

3300 Battleground Ave Ste 206

Greensboro, NC 27410

PATIENT INFORMATION

Name:_____ Date:_____/_____/_____

Date of Accident:_____/_____/_____ Time of Accident:_____:_____ AM/PM

Please describe the accident in your own words:_____

_____

_____

_____

ACCIDENT SITE

Road/Street Name:_____

City/State:_____

Nearest intersection with road/street_____

Driving Conditions ☐ Dry ☐ Wet ☐ Icy ☐ Other_____

Which direction were you headed?_____

Speed you were traveling:_____

VEHICLE

Make and model of the vehicle you were in:_____

_____

Were you wearing a seatbelt? ☐ Yes ☐ No

Was vehicle equipped with airbags? ☐ Yes ☐ No

If yes, did they inflate properly? ☐ Yes ☐ No

What the position of the headrest?

☐ Low ☐ Mid-position ☐ High

IMPACT

Did your car impact another vehicle? ☐ Yes ☐ No

Did your car impact a structure? ☐ Yes ☐ No

If yes, explain_____

_____

Did any part of your body strike anything in the vehicle?

☐ Yes ☐ No If yes, explain_____

Was impact from: ☐ Front ☐ Rear ☐ Left ☐ Right

☐ Other:_____

At the time of impact were you looking:☐ Up ☐ Down

☐ Ahead ☐ Left ☐ Right

Were both hands on the steering wheel? ☐ Yes ☐ No

If no, which hand was on the wheel? ☐ Right ☐ Left

Was your foot on the brake? ☐ Yes ☐ No

If yes, which foot was on the brake? ☐ Right ☐ Left

Were you: ☐ Surprised by impact ☐ Braced for impact

Make and model of other vehicle:_____

Which direction other vehicle headed?_____

Speed other vehicle was traveling:_____

OTHER VEHICLE

(if applicable)

POLICE

Did the police come to the accident site? ☐ Yes ☐ No

Were there witnesses? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Was a traffic violation issued? ☐ Yes ☐ No

If yes, to whom?_____

PATIENT CONDITION

Were you unconscious immediately after the accident? ☐Yes ☐ No If yes, for how long?_____

Please describe how you felt immediately after the accident:_____

_____

_____

TREATMENT

Did you go to the hospital? ☐ Yes ☐ No

When did you go? ☐ Immediately ☐ Next Day ☐ 2 or more days after

How did you get to the hospital? ☐ Ambulance ☐ Private Transportation

Name of hospital:_____ Name of Doctor_____

Diagnosis:_____

_____

Treatment received:_____

X-Rays taken:_____

SYMPTOMS/INJURIES

Have you been able to work since this injury? ☐ Yes ☐ No How many work days have you missed?_____

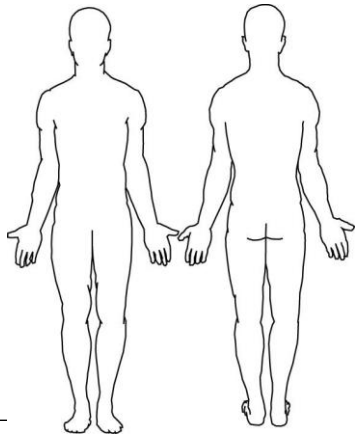
Prior to the injury were you able to work on an equal basis with others your age? ☐ Yes ☐ No

Please check the box if you have had any of these symptoms since the accident:

☐ Arm/Shoulder Pain	☐ Feet/Toe Numbness	☐ Neck Pain	☐ Back Pain	☐ Back Stiffness
☐ Headaches	☐ Shortness of Breath	☐ Chest Pain	☐ Irritability	☐ Sleep Difficulty
☐ Dizziness	☐ Jaw Problems	☐ Leg Pain	☐ Tension	☐ Stomach Upset
☐ Ear Ringing	☐ Ear Buzzing	☐ Fatigue	☐ Nausea	☐ Blurred Vision
☐ Memory Loss				

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate your pain on a scale from 1 (least pain) to 10 (severe pain)_____

Type of pain: ☐ Sharp ☐ Shooting ☐ Throbbing ☐ Numbness

☐ Aching ☐ Dull ☐ Burning ☐ Tingling

☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other_____

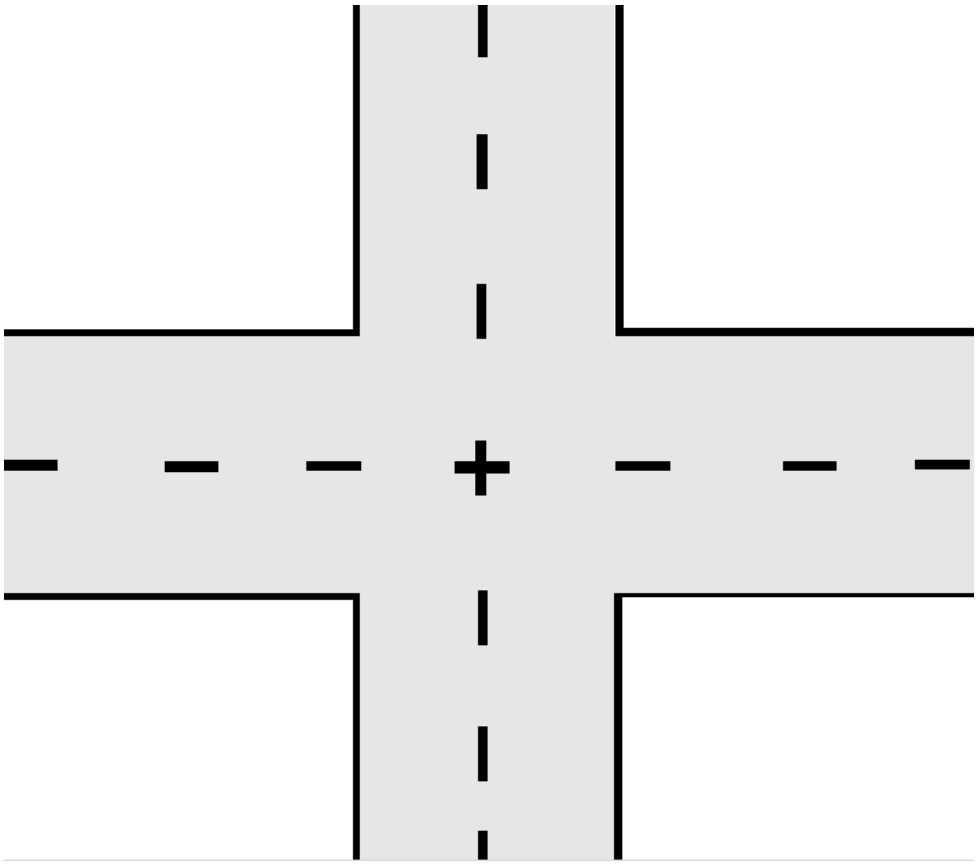
How often do you have this pain?_____

Is it constant or does it come and go?_____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Is it painful to: ☐ Sit ☐ Stand ☐ Walk ☐ Bend ☐ Lie Down

Indicate on the diagram how the accident happened and make any necessary comments or explanations:



To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative | Date

Comments:_____

_____

_____

_____

_____

_____

_____

_____