PATIENT'S REPORT OF ACCIDENT

Name _____ Date _____

Location of Accident _____ City _____

Date of Accident _____ Time _____

Was a police Report made? ☐ Yes ☐ No

Were you: ☐ Driver ☐ Passenger

Were you wearing seat belts? ☐ Yes ☐ No

Were you struck from: ☐ Behind ☐ Right Side ☐ Left Side ☐ Front

Direction of your travel: _____

Other car's direction: _____

Approximate speed of your car: _____ Other car: _____

Indicate on the diagram what happened:

How did the accident occur?

_____

_____

_____

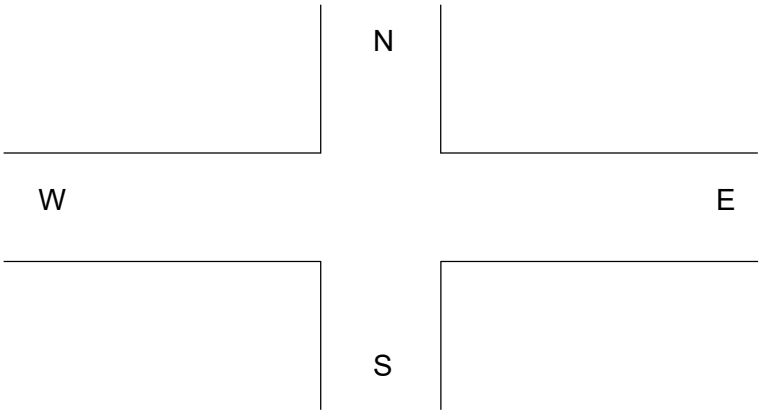
_____

_____

_____

_____

_____



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 first aid or any other treatment for this injury? _____

If yes, from whom? _____ City _____

Were you hospitalized? ☐ Yes ☐ No If yes, how long? _____

Name & city of hospital _____

Were you off work because of this injury? ☐ Yes ☐ No

If yes, the first day you were unable to work _____

Have you returned to work? ☐ Yes ☐ No If yes, on what date? _____

Did your car strike the other(s) involved ☐ Yes ☐ No

Or did, the other car strike yours ☐ Yes ☐ No

As a result of the accident were

traffic citations issued to you? ☐ Yes ☐ No

To the driver of the other car? ☐ Yes ☐ No

To the driver of your car? ☐ Yes ☐ No

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