PATIENT'S REPORT OF ACCIDENT

Name: _____ Date: _____

Email: _____ Home phone: _____ Cell: _____

Location of Accident: _____

Date of Accident: _____ Time: _____ Was a police report made? _____

Were you: ❒ Working ❒ Driving a company vehicle

Were you: ❒ Driver
❒ Passenger ❒ Front Seat ❒ Back Seat

Were you wearing seatbelts? _____ ❒ Lap ❒ Shoulder

Did the airbag (SRS) deploy? _____

Were you struck from: ❒ Behind ❒ Right side ❒ Left side ❒ Head on

Were you? ❒ Parked ❒ Moving Approximate Speed of your vehicle: _____ Other vehicle: _____

Make/Type of vehicle you were in: _____ Make/Type of other vehicle: _____

How did the accident occur?

_____

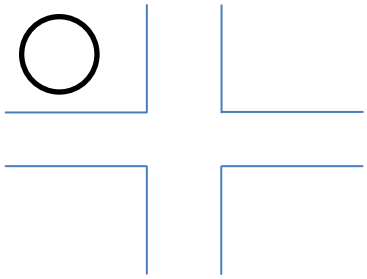
_____

_____

_____

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?

_____

Were you hospitalized? _____ If yes, how long? _____ Hospital: _____

List any physicians, chiropractors or physiotherapists you have seen prior to attendance here:

Name: _____ Location: _____
Name: _____ Location: _____
Name: _____ Location: _____

Were you off work because of this injury? _____

If yes, the first day 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 vehicle? ❒ Yes ❒ No Describe: _____
_____

Were you knocked unconscious? ❒ Yes ❒ No How long? _____

Check symptoms you have noticed since the accident:

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

Symptoms other than above: _____
_____

Insurance Companies Involved:

My company: _____ Policy #_____ Claim #_____

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

❒ Yes ❒ No

Name of Adjuster: _____
Email address: _____
Phone: _____ Fax: _____

Signature: _____ Today's Date: _____