Name: _____Date of Accident: _____ Time: _____ a.m./p.m

Where did the Accident occur?

_____

Describe the accident in your own words: _____

_____

(Please circle) In the car, were you:
Driver Front Passenger Right Rear Passenger Left Rear Passenger

At the time of impact, where you: Looking ahead Looking Right Looking Left

Were both hands on the steering wheel? _____ Was your foot on the brake? _____

Did your vehicle strike the other vehicle? Was your Car struck? Where did the impact come from?

_____

Were you braced for impact? _____Where in the car were you after the impact?_____

Were you wearing seatbelts? _____ Did you strike anything in the vehicle? _____If yes, describe:

_____

Describe how you felt immediately following impact: _____

Were you unconscious? _____In a daze? _____Did you go to the hospital? _____

Have you seen any other doctor after the incident? _____Doctor's name:_____

Is your pain constant? _____Is the pain on and off? _____Sharp? _____Dull?_____

Is your pain worse when rising from a chair? _____Is it made worse by straining? _____ Coughing? _____

Do you have any numbness or tingling in your: Arms? _____Hands? _____Fingers?_____Legs?_____

Feet? _____Toes?_____

(Please circle) What is your most comfortable position: Sitting Standing Lying Down

Does stretching and twisting worsen the pain? _____
Do you feel better moving around? _____
Resting?_____