Patient Name:_____ Date:_____

Personal Injury Form

Narrative report: please circle and/or answer the following!

What was the patient's type of vehicle (Year, make, model)? _____

What size/type of vehicle collided with patient's vehicle? Small car, Medium car, small SUV, medium SUV, large SUV, pickup truck, tractor trailer with/without load. Make/model if known_____

What was the date of the accident? _____ Were you the driver? Yes/no.

If not the driver, what position were you seated in? front seat passenger, rear left seat passenger, rear right seat passenger

Was the patient wearing a seat belt? Yes/No Did the airbag deploy? Yes/ No

Did the patient's head hit headrest? Yes/No Did you receive a head injury? Yes/No

Did you lose consciousness? Yes/ No

Where was the patient looking at the time of the impact? Left, Right, Straight ahead, over Right/Left Shoulder, down, uncertain

Did the patient contact interior of vehicle? If so, what body parts? No/ Yes:_____

Patient vehicle impacted on the? Front, Rear, Left (driver's side), right side (passenger)

Patient vehicle movement? Stopped, Forward, backwards, turning right, turning left

What was the estimated speed of the vehicle patient was driving in?_____

Patient vehicle damage? Heavy/moderate/slight

Other vehicle's movement? Stopped, Forward, backwards, turning right, turning left

If known, Speed of other vehicle?_____

How much damage is estimated to other vehicle? Heavy/moderate/slight

Was vehicle towed from the scene? Yes/No Police at the scene? Yes/No

Accident report completed by police? Yes/No Was EMS at the scene? Yes/No

Have you received any treatment since the accident? Yes/No. If so hospital name/clinic name?_____

X-rays performed? Yes/No Medications prescribed? Yes/No

Where is pain due to the accident? _____

Was pain? All of the sudden/ Came later on. If later, when was pain first noticed? _____

Additional Symptoms at the time of the accident (supplemental)? Shock, disbelief, stunned, soreness, tightness, headaches. List other here_____

Status of symptoms since the accident? Gotten better, worsened, stayed the same

What did you do from the scene of the accident? Arrange for a ride home/ Drove home/ continue on with activities/ was driven to the hospital/ Was transported to hospital by ambulance/ Other:_____

Patient Name:_____ Date:_____

HAVE YOU RETAINED AN ATTORNEY FOR THIS ACCIDENT: _____YES/_____NO

IF YES, ATTORNEY'S NAME:_____PHONE NUMBER: _____

NAME OF INSURANCE COMPANY OF THE AT FAULT PERSON: _____

NAME OF YOUR AUTOMOBILE INSURANCE: _____

NAME OF YOUR HEALTH INSURANCE: _____

ACCIDENT CLAIM NUMBER (IF KNOWN)_____