PATIENT'S REPORT OF ACCIDENT

NAME____ DATE____________________

LOCATION OF ACCIDENT___________________________ CITY______________________

DATE OF ACCIDENT ____________ TIME_____________ Was police report made? _______

Were You: Driver___ Passenger ___ Pedestrian _____

Were you struck from : Behind _______ Right Side_______ Left Side_______ Front ________

Were you wearing a seat belt? _______ Was auto parked?_______ Approx. Speed of your car_________ Other Car________

Kind of car You were in___________ Approx. damages$________ Other car____________ Approx. Damages $________

How did the accident occur? ____

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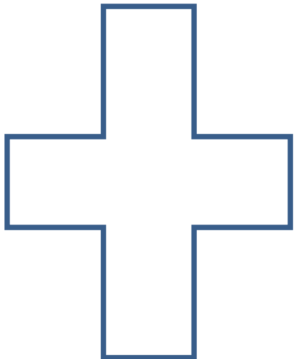
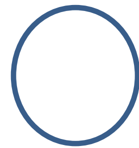
Indicate on diagram what happened



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?____

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Have you recived any first aid or any other treatment for this injury?______________________

If yes from whom?___________________________________ City____________________

Were you Hospitalized? _______ If yes, how long?___________ Name of hospital__________________________

Were you out of work because of this injury? _____ First day you were unable to work_______

Have you returned to work?________ On what date?________________________________