



**MULTICARE HEALTH CENTER**

3840 SOUTH HARLEM AVENUE

LYONS, IL 60543

P: 708.442.3050 | F: 708.442.3058

# VEHICLE ACCIDENT INFORMATION

Date \_\_\_\_\_

## PATIENT INFORMATION

Patient Name \_\_\_\_\_ Date of Accident \_\_\_\_\_ Time of Accident \_\_\_\_\_  AM  PM

Please describe the accident in your own words \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Were you the  Driver  Rear Passenger  Front Passenger  Pedestrian How many people were in the accident vehicle? \_\_\_\_\_

## ACCIDENT SITE

Road/Street Name \_\_\_\_\_ City/State \_\_\_\_\_

Nearest intersection with road/street \_\_\_\_\_

Driving conditions  Dry  Wet  Icy  Other \_\_\_\_\_

Which direction were you headed? \_\_\_\_\_ Speed you were traveling? \_\_\_\_\_

## VEHICLE

Make and Model of vehicle you were in \_\_\_\_\_

Were you wearing a seat belt?  Yes  No If yes, what type?  Lap  Shoulder

Was the vehicle equipped with airbags?  Yes  No If yes, did it/they inflate properly?  Yes  No

Did your seat have a headrest?  Yes  No If yes, what was the position of the headrest?  Low  Midposition  High

## OTHER VEHICLE (if applicable)

Make and Model of other vehicle \_\_\_\_\_

Which direction was the other vehicle headed? \_\_\_\_\_ Speed you were traveling? \_\_\_\_\_

## IMPACT

Did your car impact another vehicle?  Yes  No Did your car impact a structure?  Yes  No

If yes, explain \_\_\_\_\_

Was impact from  Front  Rear  Front  Rear  Other \_\_\_\_\_

At the time of impact were you:  Looking straight ahead  Looking to the left  Looking to the right  Looking down  Looking up

Were both hands on the steering wheel?  Yes  No If no, which hand was on the wheel?  Left  Right

Was your foot on the break?  Yes  No If yes, which foot was on the break?  Left  Right

Were you  Surprised by the impact  Braced for impact

## POLICE

Did the police come to the accident site?  Yes  No Were there any witnesses?  Yes  No

Was a police report filed?  Yes  No Was a traffic violation issued?  Yes  No If yes, to whom? \_\_\_\_\_

## PATIENT CONDITION

Were you unconscious immediately after the accident?  Yes  No If yes, for how long? \_\_\_\_\_

Please describe how you felt immediately after the accident \_\_\_\_\_

## TREATMENT

Did you go to the hospital?  Yes  No When?  Immediately after accident  Next day  2 days or more after the accident

How did you get to the hospital?  Ambulance  Private transportation

Name of hospital \_\_\_\_\_ Name of doctor? \_\_\_\_\_

Diagnosis \_\_\_\_\_

Treatment received \_\_\_\_\_

X-ray taken \_\_\_\_\_

## SYMPTOMS/INJURIES

Have you been able to work since this injury?  Yes  No How many work days have you missed? \_\_\_\_\_

Prior to the injury were you able to work on an equal basis with others your age?  Yes  No

If you have had any of the following symptoms since your injury, please check the ones that apply:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Arm/shoulder pain | <input type="checkbox"/> Feet/toe numbness    | <input type="checkbox"/> Neck pain           |
| <input type="checkbox"/> Back pain         | <input type="checkbox"/> Hand/finger numbness | <input type="checkbox"/> Neck stiffness      |
| <input type="checkbox"/> Back stiffness    | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Chest pain        | <input type="checkbox"/> Irritability         | <input type="checkbox"/> Sleep difficulty    |
| <input type="checkbox"/> Dizziness         | <input type="checkbox"/> Jaw problems         | <input type="checkbox"/> Stomach upset       |
| <input type="checkbox"/> Ear buzzing       | <input type="checkbox"/> Leg pin              | <input type="checkbox"/> Tension             |
| <input type="checkbox"/> Ear ringing       | <input type="checkbox"/> Memory loss          | <input type="checkbox"/> Vision blurred      |
| <input type="checkbox"/> Fatigue           | <input type="checkbox"/> Nausea               |  |

Is this condition getting progressively worse?  Yes  No  Unknown

Mark X on the picture where you continue to have pain, numbness or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) \_\_\_\_\_

Type of pain:  Sharp  Dull  Throbbing  Numbness  
:  Aching  Shooting  Burning  Tingling  
 Cramps  Stiffness  Swelling  Other \_\_\_\_\_

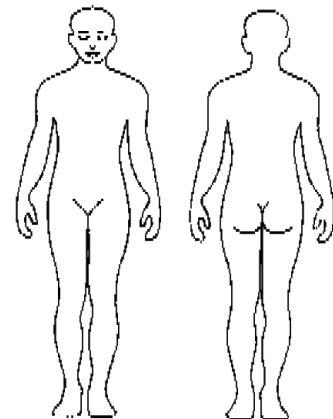
How often do you have this pain? \_\_\_\_\_

Is it constant or does it come and go? \_\_\_\_\_

Does interfere with your:  Work  Sleep  Daily Routine  Recreation

Movements that are painful to perform

- Sitting  Standing  Walking  Bending  Lying Down



To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

\_\_\_\_\_  
*Signature of Patient, Parent, Guardian or Personal Representative*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Please print name of Patient, Parent, Guardian or Personal Representative*

\_\_\_\_\_  
*Relationship to Patient*