# ACCIDENT REPORT – Personal Injury

NAME:_____DATE:_____

Address:_____

SS#_____-_____-_____ Home Phone:_____Work Phone:_____

Date of accident:_____Hour_____AM/PM Location:_____
How did the accident occur? _____Auto collision _____Other_____
Please describe the circumstances: _____
_____
_____

List the extent of your injuries as you know them:_____
_____
_____

Did you require post-accident hospitalization: _____Yes _____No
Other doctors you have seen: Dr. _____ Date:_____ Treatment:_____
Dr. _____ Date:_____ Treatment:_____

Check symptoms/complaints you have noticed **SINCE THE ACCIDENT**:

1. ____ Shortness of breath
2. ____ Excessive Perspiration
3. ____ Mid back pain/stiff
4. ____ Low back pain/stiff
5. ____ Feet/Hands cold
6. ____ Restrictions of neck motion
7. ____ Upper back pain/ stiffness
8. ____ Buzzing and or ringing in ears
9. ___ Eyes sensitive to light; loss of focus
10. ___ Head/Shoulders feel heavy
11. ___ Pins/needles in arms and legs
12. ____Difficulty riding in car
13. ____Headache
14. ____Neck pain
15. ____Neck stiffness
16. ____Insomnia
17. ____Tension
18. ____Irritability
19. ____Loss of taste
20. ____Loss of smell
21. ____Loss of memory
22. ____Diarrhea
23. ____Neuritis
24. ____Anxiety
25. ____Fainting
26. ____Chest pain
27. ____Dizziness
28. ____Constipation
29. ____Eyestrain
30. ____Nausea/vomiting
31. ____Face flushed
32. ____Palpitation
33. ____Tremors
34. ____Sinus trouble
35. ____Mental dullness
36. ____Extreme nervousness
37. ____Extreme fatigue
38. ____Pain behind eyes
39. ____Double vision
40. ____Digestive disorders
41. ____Equilibrium problems
42. ____Head seems heavy
43. ____Difficulty in excessive
    ____Standing ____Walking
    ____Riding ____Bending
44. ____Neck pain/stiffness upon arising
45. ____Low back pain/stiff upon arising _
46. ____Pain radiating into
    ____Arm ____Left
    ____Leg ____Right
    ____Both ____Both
47. ____Difficulty in lifting
    ____Light ____Moderate
    ____Heavy ____Repetitive
48. ____Pain radiating into
    ____Neck
    ____Base of skull
    ____Shoulder
    ____Arms
    ____Hips
    ____Legs

Symptoms other than above:
_____
_____
_____
_____
_____
_____
_____

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