# MOTOR VEHICLE ACCIDENT REPORT

Date:________________

## PATIENT INFORMATION

Name:____________________________ Birthdate:_________________________________
Carecard#:_____________________________
Accident Date:____________________ Claim#:____________________________________
Adjuster's Name:___________________ Adjusters email:_____________________________
Law firm:__________________________ Firm Ph #:__________________________________

## ACCIDENT DETAILS

Describe how the accident happened
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

At what angle was the vehicle struck?
Front Back Right side Left side

Describe any immediate and noticeable injuries________________________________________________________________
_________________________________________________________________________________

Could you move all parts of your body? YES NO
If no, please specify_____________________________________________________________________
_________________________________________________________________________________

Were you the driver? YES NO
Were you wearing a full seatbelt? YES NO
Did you have a head rest? YES NO
Were you conscious at all times? YES NO
Could you walk? YES NO
Were you aware of the impending collision? YES NO

In what position was your head facing at impact?
Forward Turned right Turned Left

Did your head or any part of your body make
contact with the inside of the vehicle? YES NO
Were you examined immediately after the accident? YES NO
Were you taken to the hospital? YES NO
If so, did they use a stretcher? YES NO
Did they use a neck brace? YES NO
Was an X-ray taken? YES NO
Have you seen a doctor since the accident? YES NO

State specifically how you felt the next day______________________________________________________________________________
______________________________________________________________________________________

Since the accident has your pain? Decreased Spread Intensified

Have you had any of the following since the accident?

| | | |
|---|---|---|
| Headaches | Fatigue | Insomnia |
| Fainting | Dizziness | Loss of balance |
| Ringing in ears | Depression | Muscle spasm in neck/back |
| Shooting pains | Painful joints | Tightness of shoulder |
| Loss of smell/taste | Loss of memory | Eye/ears/face problems |
| Painful joints | Anxiety | Shortness of breath |
| Sweating | Irritability | Pain in legs and feet |
| Stiffness | Vision problems | Inflammation/pain in throat |
| Difficulty swallowing | Chest pain | Digestive problems |
| Decreased appetite | Loss of interest | Pins and needles |

Other________________________________________________________________________________

Which activities are hard to perform since the accident?
Lifting Sitting Bending Walking Laying Reaching Turning Twisting

What type of pain do you have?
Burning Aching Shooting Dull Sharp Stabbing Tingling Numbness

Rate your typical pain on a scale from 1 to 10 (1 Mild- 10 Severe)
1 2 3 4 5 6 7 8 9 10
Is your pain constant? YES NO
Have you had to take time off work because of the accident? YES NO
Have you found anything that helps reduce your pain? YES NO
If yes, what?________________________________________________________________________