KENTUCKY PAIN INSTITUTE

Auto Accident Information

Today's Date: _____/_____/_____ Name: ______________________________

1.) Speed limit on the road where accident occurred: ____________________

2.) Estimated rate of speed upon impact: ____________________

3.) Traffic conditions:
❒ Congested ❒ Good ❒ Heavy ❒ Normal ❒ Rush Hour

4.) Vehicle make, year, and ownership:
____

5.) Side of impact:
❒ Front ❒ Rear ❒ Left side ❒ Right side

6.) Description of accident and road accident occurred on:
____
____
____
____

7.) Did vehicle travel off road? ❒ No ❒ Yes

8.) Weather conditions:
❒ Foggy ❒ Normal ❒ Poor visibility ❒ Raining ❒ Snowing ❒ Windy

9.) Accident responded to? ❒ No ❒ Yes; (please check all that apply)
❒ Ambulance ❒ Police Department:______________ ❒ Fire Department ❒ Other:______________

10.) Citation given to:______________________________

11.) Was an injury/accident report filed? ❒ No ❒ Yes

12.) Witness of accident: ______________________________

13.) Status before accident:
❒ Asleep ❒ Awake ❒ Shoulder Harness Off ❒ Rotated in Seat ❒ Seat Belt Off
❒ Seat Belt On ❒ Tired ❒ Shoulder Harness On ❒ Reclined in Seat ❒ Other: __________

14.) Body Parts Struck: ______________________________

Name:____________________________________ **Today's Date:**_______________________

15.) Patient Position: ❒ Driver ❒ Passenger:
❒ Front Middle Seat ❒ Front Right Seat ❒ Middle Left Seat ❒ Middle Center Seat
❒ Middle Right Seat ❒ Back Left Seat ❒ Back Middle Seat ❒ Back Right Seat

16.) Length of time in vehicle prior to accident: ____

17.) Capacities AFTER Accident:

Bending:	❒ Normal	❒ Difficult	❒ Limited	❒ Painful
Lifting:	❒ Normal	❒ Difficult	❒ Limited	❒ Painful
Sitting:	❒ Normal	❒ Difficult	❒ Limited	❒ Painful
Standing:	❒ Normal	❒ Difficult	❒ Limited	❒ Painful
Walking:	❒ Normal	❒ Difficult	❒ Limited	❒ Painful

18.) Capacities BEFORE Accident:

Bending:	❒ Normal	❒ Difficult	❒ Limited	❒ Painful
Lifting:	❒ Normal	❒ Difficult	❒ Limited	❒ Painful
Sitting:	❒ Normal	❒ Difficult	❒ Limited	❒ Painful
Standing:	❒ Normal	❒ Difficult	❒ Limited	❒ Painful
Walking:	❒ Normal	❒ Difficult	❒ Limited	❒ Painful

19.) Condition interferes with:
❒ Activities of Daily Living ❒ Patient's Normal Lifestyle ❒ Patient's Work Activities

20.) Were you hospitalized? ❒ No ❒ Yes; Where:____

21.) Location taken after accident:
❒ Home
❒ Emergency Room; Where: ____
❒ Minor Emergency Center; Where: ____
❒ Other: ____

22.) After the accident, have you been able to do mental work? ❒ No ❒ Yes

23.) After the accident, have you been able to do physical work? ❒ No ❒ Yes

24.) Did you remain conscious after the accident? ❒ No ❒ Yes

25.) Do you remember the Impact? ❒ No ❒ Yes

26.) Have you lost time from work? ❒ No ❒ Yes; List From and To dates:_________________________

27.) Are you limited in movement? ❒ No ❒ Yes

28.) Is riding in a car bothersome? ❒ No ❒ Yes

29.) Have you received outside help for household tasks or personal care? ❒ No ❒ Yes

30.) Time of accident:
❒ Dawn ❒ Daylight ❒ Dusk ❒ Night