POPWELL•SCOTA SPINE CENTER
ACCIDENT REPORT FORM

Patient Name____Date___________________

Date, time and location of accident____

____

Have you had previous complaints in the injured area? Y N

Have you lost any days from work as a result of this accident? Y N

Have you ever had an accident claim before? Y N Describe_________________________________

____

Are you retaining an attorney for this accident? Y N If so, whom?____________________________

***************************AUTO ACCIDENTS****************************

Were you: Driver Passenger Pedestrian Front Seat Back Seat Using Seat Belt

Who else was in the car with you?____

What type of vehicle were you driving?____________________Approx. Amt. Of Damage $_____________

What other type of vehicle was involved__________________Damage: None Minimal Heavy

When did you first notice symptoms?____

Did you lose consciousness? Y N If so, how long?____

How fast were you driving?________MPH How fast was the other car driving?________MPH

Your head was in what position? Straight Turned Left Right

Did you see the accident coming? Y N Were the police notified? Y N

As a result of the accident, were traffic citations issued to you? Y N

Did your car strike the other(s) involved? Y N Did others strike you? Y N

Were you struck from: Behind Front Left Side Right Side Left Rear Right Rear

What happened after the accident? Drove yourself to the hospital/home. Taken to emergency room.
Other:____

What treatment was given?____X-rays? Y N

*****************WORKERS COMPENSATION INJURIES*****************

Did you report the injury to your foreman or employer? Y N Name:__________________________

Did they recommend care at our office? Y N

Did you fill out a notice of injury? Y N Did you bring a copy? Y N

Did you continue to work after the accident? Y N

If injured before, did you lose time from work? Y N