PATIENT'S ACCIDENT REPORT

DATE:_____
NAME OF INJURED PERSON:_____AGE:____SEX:____
ADDRESS:_____
SOCIAL SECURITY NUMBER:_____
NAME AND ADDRESS OF EMPLOYER:_____
_____
PERSON REPORTED INJURY TO:_____

DATE OF INJURY:_____ AM PM DATE OF FIRST SYMPTOM:_____
DATE OF FIRST TREATMENT: _____

PATIENT'S ACCOUNT OF HOW INJURY OCCURRED: _____
_____
_____
_____

PAIN LEVEL SELECT THE BEST DESCRIPTION:

BEGINNING	AT PRESENT	
_____	_____	Pain present but forgotten with activity.
_____	_____	Annoying, does not interfere with activity but is not forgotten.
_____	_____	Requires modification of activity but is not disabling.
_____	_____	Unable to perform duties as normal due to pain.
_____	_____	Causes you to cry out in pain, disabling.
_____	_____	Other Describe:_____

AGGRAVATED BY (Makes condition worse):_____
_____

RELIEVED BY:_____
_____

HAVE YOU LOST TIME FROM WORK: Yes No DURATION:_____

HAVE YOU SEEN ANY OTHER PHYSICIANS FOR INJURY: Yes No
List_____.

WERE DRUGS PRESCRIBED BY A PHYSICIAN: Yes No
List_____.

WERE YOU **HOSPITALIZED**: Yes No WHERE:_____.

OTHER **IMPORTANT FACTS** IN REGARDS TO THE INJURY:_____
_____.

HAVE YOU EVER HAD SAME INJURY BEFORE: Yes No
Describe_____.

HAVE YOU EVER HAD OTHER AUTO OR JOB INJURIES BEFORE: Yes No
Describe_____.

Signature _____.