20. The other vehicle: ☐ Backing up ☐ Moving forward ☐ Stopped ☐ Turning left ☐ Turning right

21. What was the approximate speed at the time of the impact? Other vehicle: _____

22. Other vehicle's damage: ☐ heavy visible damage ☐ moderate visible damage ☐ slight visible damage
☐ no visible damage ☐ totaled ☐ unknown

23. Was your vehicle towed from the scene? ☐ Yes ☐ No

24. What were the road conditions at the time of the accident? ☐ Wet ☐ Dry ☐ Snow ☐ Ice

25. Were police at the scene? ☐ Yes ☐ No

26. Was there an accident report made? ☐ Yes ☐ No

27. Were there EMS at the scene? ☐ Yes ☐ No

28. Did you go to the hospital? ☐ No, arranged for a ride home ☐ No, continued on with activities ☐ No, denied transport
☐ No, drove home ☐ Yes, was driven to hospital ☐ Yes, was transported to the local hospital ☐ Yes, drove self

If you went to the hospital, please answer the following:

Hospital: _____ Doctor: _____

29. Have you received treatment since the accident? ☐ not treated ☐ admitted to hospital ☐ examined
☐ prescribed medication ☐ x-rays ☐ referred to another provider ☐ treated self with ice pack
☐ treated self with hot pack ☐ treated self with over the counter medication ☐ treated self with rest

30. Describe your symptoms at the time of the accident: ☐ache ☐annoying ☐ burning ☐ deep pain
☐ dull ☐ headache ☐ intolerable ☐ muscle spasms ☐ numbness ☐ numbness in extremities
☐ sharp ☐ shooting ☐ stabbing ☐ stiff ☐ tender ☐ throbbing ☐ tingling ☐ tingling in extremities

31. Where on your body did you feel these symptoms? _____

32. Additional symptoms at time of accident: ☐ anxiety ☐ difficulty breathing ☐ chest pain ☐ dizziness
☐ irritability ☐ loss of appetite ☐ shock ☐ Other _____

33. How have symptoms changed since the accident? ☐ more pain ☐ more stiffness ☐ worsened
☐ worsened quality of life ☐ no change in daily activities ☐ improved ☐ stayed the same ☐ resolved

34. Have you lost any days of work due to your injury? ☐ Yes ☐ No

Date: _____ **Patient Signature:** _____