Patient Accident Report

Patient Name: Print _____ Signature: _____ Date: _____

MVA

Insurance Company: _____ Insurance Address: _____

Policy Number: _____ Adjuster's Name: _____

WSIB

WSIB Number: _____ Adjudicator's Name: _____

Social Insurance Number: _____

1. Accident Date: _____ Time: _____

2. Location of accident: _____

Describe accident and how you were felt immediately after the accident (mention if you had any faint, numb, instant pain in neck, low back or mid back etc. _____

3. Describe any cuts or bruises you sustained. _____

4. Could you move all parts of your body? _____ If no, specify _____

5. Could you walk? _____ Were you conscious at all times? _____

6. Describe how you felt that evening _____

Could you sleep? _____

7. Did the pain get worse, spreading or intensifying? If so, describe where it radiated, which side hurt, whether it hurt more to stand and bend over slightly, or more to bend all the way _____

8. What makes the pain better or worse? _____

9. Do you feel like you are losing strength in your arms, hands or legs? _____

10. State specifically how you felt the day after the accident. _____

11. Where were you examined first?_____

When?_____

What was done?(X-ray, medication, examination, etc)_____

_____

12. What were you told and given?_____

_____

13. Did you see any other doctors? _____If so, who and when?_____

14. Did you stay in hospital?_____ If so, where and how long?_____

15. If you did not stay in hospital were you recommended to be hospitalized?_____

16. Check any of the following symptoms you have now or had after the accident

□Headaches	□Shooting head pains	□Fatigue
□Depression	□Ring in ears	□Dizziness
□Fainting	□Loss of balance	□Cold hands
□Muscle spasm in neck	□Grating in neck	□Muscles spasm in back
□Neuritis in shoulders and arms	□Chest pain	□Shortness of breath
□Inner tension	□Swollen joints	□Sweating
□Irritability	□Pain in legs or feet	□Painful joints
□Tightness of shoulder muscles	□Inflammation or pain in the throat	

Complaints in:	□eyes	Loss of:	□memory	Pins and needles in:	□arms
	□ears		□smell		□legs
	□face		□taste		□hands

17. Do you suffer an impairment that substantially prevents you from engaging in pre-accident caregiving activities? □ Yes □ No □ Not Applicable. If yes, please describe the activities you cannot perform. _____

_____

18.Do you suffer an impairment that prevents you from carrying on substantially all your normal pre-accident activities? □ Yes □ No If yes, please describe the activities you cannot perform. _____

_____

19.Do you suffer from an impairment that substantially prevents you from performing pre-accident housekeeping and/or home maintenance activities? □ Yes □ No If yes, please describe the activities you cannot perform._____

_____

_____

Hurt on the Job

20. In addition to the above, were there any witnesses?_____

21. Was the accident reported to a supervisor?_____

22. Was an accident report filed?_____