Health Back Center
Dr. Rebecca L. Pearson
417-337-7100

INCIDENT/ACCIDENT/INJURY INFORMATION FORM

❑ Auto

Were you the ❑ Driver ❑ Front Seat Passenger ❑ Back Seat Passenger ❑ Pedestrian?
Number of people in your vehicle? _____ Number of people in the other vehicle? _____
What direction were you headed? ❑ North ❑ South ❑ East ❑ West on (Name of Street) _____
Other vehicle was headed: ❑ North ❑ South ❑ East ❑ West on (Name of Street) _____
Were you struck from: ❑ Behind ❑ Front ❑ Left Side ❑ Right Side
or did you strike the other car with your ❑ Front End ❑ Rear End
Were you wearing your seat belt? ❑ Yes ❑ No
Briefly describe the accident including cause(s) and surrounding circumstances: _____

❑ Other

Briefly describe the accident including cause(s) and surrounding circumstances: _____
Name of anyone else involved in the accident: _____
Name of responsible party: _____ Phone: _____
Street: _____ City: _____ State: _____ Zip: _____

❑ Fall

Describe conditions: _____
If appropriate, which body part struck the surface, floor, etc.? _____
If in a public place, was property manager notified? ❑ Yes ❑ No
Property Name: _____ Property Manager's Name: _____
Manager's Response: _____

❑ Work Related Accident

Employer: _____ Phone: _____
Street: _____ City: _____ State: _____ Zip: _____
Your job title: _____ Dept: _____
Was any equipment, machinery, and/or object related to the accident? ❑ Yes ❑ No
If yes, what kind? _____
Was the accident reported to the supervisor/employer? ❑ Yes ❑ No
Was a Workers' Compensation claim filed? ❑ Yes ❑ No
Did your supervisor/employer recommend care at our office? ❑ Yes ❑ No

Patient's Signature: _____ Date: _____

Clinic Address:
3265 Falls Center, Suite H
Branson, MO 65616

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