AUTOMOBILE ACCIDENT HISTORY

CONTACT :

Name: ____________________ Age: __________ Date of Birth____________________ ❑ M ❑ F

Address____________________ City __________ State ______ Zip ________

SS# ____________________ Drivers License # ____________________

Insurance Co. ______________ Policy # ______________ Claim # ______________

Address of Ins. Co. ____________________ City __________ St ______ Zip________

Have you retained an attorney? ❑ Yes ❑ No Name and address of attorney____________________

____

GENERAL SYMPTOMS:

Did you hit any part of your body during the collision--for example, head on dash, chest on steering wheel? ❑Yes ❑No

If YES, which part and how? ____________________

Where were you taken after the accident? ____________________

Were you hospitalized? ❑ Yes ❑ No If YES, for how long? ____________________

Did you receive care from any other health care specialist? ❑ Yes ❑ No

If YES, what is the specialist's name? ____________________

What type of care were you given and for how long? ____________________

Where do you feel the pain? ____________________

What are your current symptoms? ____________________

Have you ever been injured in a similar manner? ❑ Yes ❑ No If yes, how and when? ____________________

____

ACCIDENT HISTORY:

Date of Accident: ______________ Time of Accident: __________ ❑ A.M ❑ P.M

State how the accident happened, in your own words: ____________________

____

____

What type of vehicle were you in? Make: __________ Model: __________ Year: ________

Were you driving? ❑ Yes ❑ No Was it your car? ❑ Yes ❑ No If not yours, whose? ______________

Were you a passenger? ❑ Yes ❑ No

- If YES, were you seated in: ❑ Front ❑ Back ❑ Right Side ❑ Left Side

Were you rotated in the seat? ❑ Yes ❑ No

Were you reclined in the seat? ❑ Yes ❑ No

Were there other people in the car? ❑ Yes ❑ No

- If YES, Please list names and addresses: ____________________

____

- If YES, were they injured? ❑ Yes ❑ No If YES, please explain: ____________________

____

Seat belts on? ❑ Yes ❑ No Shoulder harness on? ❑ Yes ❑ No Position of headrest: __________

Was it: ❑ Daylight? ❑ Night? ❑ Dusk? ❑ Dawn? What were the weather conditions? __________

Were you tired? ❑ Yes ❑ No Were you awake? ❑ Yes ❑ No How long had you been in the car? ________

Where were you prior to the accident? ____________________

What were the traffic conditions? ____________________ What was the posted speed limit? __________

How fast were you going? ______________ Type of road: ❑ 2 Lane ❑ 4 lane ❑ Gravel ❑ Tar

Did it happen at a/an: ❑ stop sign? ❑ traffic light? ❑ intersection? ❑ highway?

(continued on next page)

Was your car hit? ❑ Yes ❑ No If YES, where was it hit? ❑ Front ❑ Rear ❑ Left side ❑ Right side

What damage was done to your car?
Inside: ______________________________
Outside: ______________________________
Other: ______________________________

If you struck another car, did you strike it: ❑ Front ❑ Rear ❑ Side What was the damage to the other car?
Inside: ______________________________
Outside: ______________________________

In what condition was the vehicle prior to the accident? ______________________________

Do you have pictures of the other involved vehicle? ❑ Yes ❑ No What type of vehicle was involved in the accident?
❑ Car ❑ Truck ❑ Motorcycle ❑ Other: ____________ Size and Type: ____________

Was an accident report made? ❑ Yes ❑ No Police of: City: __________ County: ________ State: _____

Who was ticketed? ____________________ For what? ____________________

Did your vehicle strike anything? ❑ Yes ❑ No If yes was it: ❑ Another car? ❑ Sign? ❑ Bridge? ❑ Hedge?
❑ Embankment? ❑ Other: ____________________ Size and type: ____________________

Were you completely conscious after the impact? ❑ Yes ❑ No

Do you remember the impact? ❑ Yes ❑ No Did your vehicle go off the road? ❑ Yes ❑ No

If so, ❑ Into a ditch? ❑ An embankment? How deep? ____________________

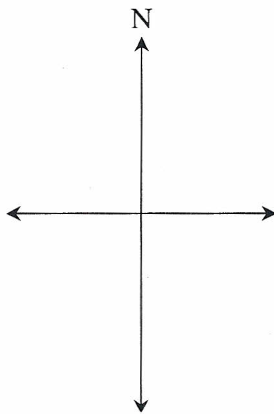
Does it bother you to ride in a car now? ❑ Yes ❑ No If so, as a ❑ Driver ❑ Passenger

State any strange events that happened during or immediately after the accident ____________________

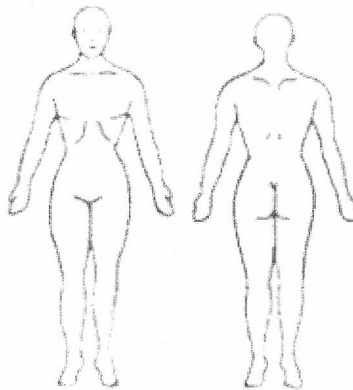
____

Have you had any time loss from work? ❑ Yes ❑ No If yes, from __________ to __________

Have you had to have any outside help? ❑ Yes ❑ No If yes, what type? ____________________



Please draw the accident



MARK PAIN AREA

+++ Burning
000 Stabbing
- - - Sharp
| | | Constant

______________________ Patient Name (Please print)

______________________ Date

______________________ Patient Signature

______________________ Staff Signature