AUTOMOBILE ACCIDENT HISTORY

Name: __________________________ Age: ___________ D.O.B.: _________ □M □F

Address: ________________________City: ____________ State: _______ Zip Code: _______

Telephone: ___________________SS#: __________________Driver's Lic. #: ___________

Insurance Company: _________________________________Telephone #: _____________

Have you retained an attorney? □Yes □No If yes, Name: ______________________________

Address: ___________________________________ Telephone #: ____________________

GENERAL SYMPTOMS:

Did any part of your body hit any part of the car during the collision? Ex.: head on dash, 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, from whom?

____ Telephone #: ___________________

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

Where did you feel the pain? ______________________________ Was it immediate? _____

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, whose? _____________

Were you a passenger? □Yes □No □Front □Back □Right Side □Left Side

Were you rotated in the seat? □Yes □No Were you reclined? □Yes □No Other: ____

Other people in the car? □Yes □No Names: ________________________________

____

Were they injured? □Yes □No If yes, explain: ________________________________

Seat belts on? □Yes □No Shoulder harness on? □Yes □No Position of headrest: □Up □Down

Was it? □Daylight □Night What were the weather conditions? ______________________

Were you tired? □Yes □No Were you awake? □Yes □No How long had you been in the car? ___________________minutes/hours

What were the traffic conditions? _____________________ How fast were you going? ______

Did it happen at a/an: □Stop sign □Traffic light □Intersection □Highway

Where was your car hit? □Front □Back □Right Side □Left Side

Was damage done to your car?

Inside: ____

Outside: ____

Other: ____

If you struck another car, did you strike it: □Front □Back □Side What was the damage to the other car?

Inside: ____

Outside: ____

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

What type of vehicle was involved in the accident? □Car □Truck □Motorcycle
□Other______________________ Size and Type: ___________________________

Was accident report made? □Yes □No (Police of) City: _____________Cty.: ______State:____

Who was ticketed? ______________________ For what? ____________________________

Did your vehicle strike anything? □Yes □No If yes, □Another car □Sign □Tree □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, □hit an embankment? □into a ditch?

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? ______________

____________________________________ ___________________________

Patient Signature Date