AUTOMOBILE ACCIDENT HISTORY

Name:_____ Age:_____ Date of Birth:_____ ☐ M ☐ F

Address:_____

City:_____ State:_____ Zip:_____

Insurance Company:_____ Phone:_____

Address of Insurance Company:_____

Insurance Policy #:_____Claim#:_____

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 did 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: _____ ☐ AM ☐ PM

State how the accident happened in your own words:_____

_____

_____

What type of vehicle were you in? Make:_____ Year:_____

Were you driving? ☐ Yes ☐ No | Was it your car? ☐ Yes ☐ No | If not whose? _____

☐ Passenger ☐ Front ☐ Back ☐ Right side ☐ Left side | Were you rotated in seat? ☐ Yes ☐ No

Were you reclined? ☐ Yes ☐ No Other:_____

Other people in car? ☐ Yes ☐ No | Names and Addresses: _____

_____

Were they injured? ☐ Yes ☐ No | If yes, explain:_____

_____

Seat belts on? ☐ Yes ☐ No | Shoulder harness? ☐ Yes ☐ No | Position of headrest: _____

Was is: ☐ 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

Where was your car hit? ☐ Front ☐ Back ☐ Left side ☐ Right side | What damage was done to your car?

Inside: _____

Outside: _____

Other: _____

If you stuck another car, did you strike it: ☐ Front ☐ Back ☐ 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 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: ☐ 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 you 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 | What type? _____

_____ _____ _____

Patient Signature Date Staff Signature