AUTOMOBILE ACCIDENT HISTORY

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

Address:_____

City:_____ State:_____ Zip:_____

Insurance Company:_____ Phone:_____

Do you have Medpay? ☐ Yes ☐ No | Address of Insurance Company (**Claims Department**):

_____

Insurance Policy #:_____Claim#:_____

Claim Adjuster Name and Phone #:_____

Have you retained an attorney? ☐ Yes ☐ No | Name, Address, and Phone # 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