MOVEMENT CLINIC

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Auto Accident History

Accident Information

Name: _____ Date: _____

Date of accident: _____ Time: _____ ☐ AM ☐ PM

Driver of car: _____ Where were you seated? _____

Owner of car: _____ Year and model of car: _____

Visibility at time of accident: ☐ Poor ☐ Fair ☐ Good ☐ Other: _____

Road conditions at time of accident: ☐ Icy ☐ Rainy ☐ Wet ☐ Clear ☐ Dark ☐ Other: _____

Where was your car struck? ☐ Right ☐ Left ☐ Rear ☐ Front ☐ Side ☐ Other: _____

Type of accident: ☐ Head-on collision ☐ Broad-side collision ☐ Rear-end collision

☐ Front impact, rear-ended car in front ☐ Non-collision: _____

What part of the car was damaged? _____

Describe what happened to you upon impact? _____

Did you see the accident was about to happen? ☐ Yes ☐ No

Did you brace for impact? ☐ Yes ☐ No

Were you wearing a seatbelt? ☐ Yes ☐ No

Were you wearing a shoulder harness? ☐ Yes ☐ No

Does the car have headrests? ☐ Yes ☐ No

If yes, what was the position of your headrest?

☐ Top of headrest even with bottom of head

☐ Top of headrest even with top of head

☐ Top of headrest even with middle of head

Was your car braking? ☐ Yes ☐ No

Was the other car braking? ☐ Yes ☐ No

Was your car moving at the time of the accident? ☐ Yes ☐ No

If yes, how fast would you estimate you were going? _____

How fast would you estimate the other car was traveling? _____

What was the position of your head and body at the time of impact?

☐ Head turned left/right ☐ Body straight in sitting position ☐ Head looking back

☐ Body rotated left/right ☐ Head straight forward ☐ Other: _____

At the time of the accident, recall what parts of your head or body hit what parts of the vehicle:

_____

_____

As a result of the accident were you: ☐ Rendered unconscious ☐ Dazed ☐ Other: _____

Could you move all parts of your body? ☐ Yes ☐ No

If no, why not? _____

Were you able to get out of the car and walk unaided? ☐ Yes ☐ No

If no, why not? _____

Did you have any cuts or bruises from this accident? ☐ Yes ☐ No

If so, where? _____

Describe how you felt immediately after the accident: _____

How did you feel later that ☐ day ☐ night? _____

How did you feel the next day(s)? _____

Check symptoms apparent **since** the accident:

☐ Headache	☐ Loss of smell	☐ Numbness in fingers	☐ Other: _____
☐ Loss of taste	☐ Cold hands	☐ Mid-back pain	☐ Loss of memory
☐ Cold feet	☐ Low-back pain	☐ Fatigue	☐ Ringing in ears
☐ Tension	☐ Constipation	☐ Pain behind eyes	☐ Shortness of breath
☐ Chest pain	☐ Dizziness	☐ Irritability	☐ Nervousness
☐ Fainting	☐ Depression	☐ Cold sweats	☐ Eyes sensitive to light
☐ Sleeping problems	☐ Loss of balance	☐ Numbness in toes	
☐ Diarrhea	☐ Anxious	☐ Neck pain/stiffness	

Have you missed time from work? ☐ Yes ☐ No Work hours are: ☐ Full-time ☐ Part-time

If you have missed time from work, how much time have you missed? _____

Did the accident occur during your work hours? ☐ Yes ☐ No

Did you seek medical help immediately/soon after the accident? ☐ Yes ☐ No

If yes, how did you get there? _____

Doctor/hospital/clinic seen: _____ Date: _____

What was done? _____

Were x-rays or other imaging taken? ☐ Yes ☐ No

If yes, of what body part? _____

What treatments/prescriptions were given? ☐ Bed rest ☐ Brace ☐ Medications ☐ Other: _____

What benefit(s) did you receive from treatment(s)?

_____

_____

Date of last treatment: _____

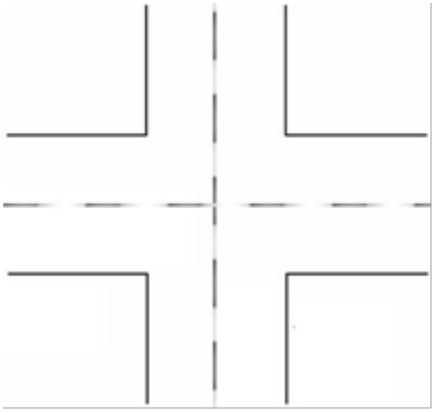
Are any of your activities of daily living any different now compared to before the accident?

List anything you are unable to do: _____

List anything that is painful to do: _____

List anything that is difficult to do: _____

Indicate on the diagram below how the accident happened.



Comments:

_____

_____

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Insurance Information

Do you have an attorney handling this case? ☐ Yes ☐ No

Attorney Name: _____

Attorney Address: _____

Patient's personal insurance: _____

Insured's name (if other than patient) _____ Policy # _____

Insurance Company Name: _____

Phone # _____

Address: _____ City: _____

State: _____ Zip: _____

Claim # _____

Adjuster's name and phone # _____

Other party's insurance: _____

Insured's name (if other than patient) _____ Policy # _____

Insurance Company Name: _____

Phone # _____

Address: _____ City: _____

State: _____ Zip: _____

Claim # _____

Adjuster's name and phone #_____

Other insurance: _____

Insured's name (if other than patient) _____ Policy # _____

Insurance Company Name: _____

Phone # _____

Address: _____ City: _____

State: _____ Zip: _____

Claim # _____

Adjuster's name and phone # _____

Patient's Demographic Information

Patient's full name: _____

Social Security # _____

Address: _____ City: _____

State: _____ Zip: _____

Date of birth: _____

Mailing address (if different): _____

Primary phone # _____

Employer name: _____

Occupation: _____

Employer's address: _____ City: _____

State: _____ Zip: _____

Work phone # _____

Spouse's name: _____

Spouse's Social Security # _____

Spouse's employer: _____

Occupation: _____

Assignment of Payment

My attorney and/or insurance carrier are hereby requested and authorized to pay direct to **Movement Clinic** any monies due on account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay **Movement Clinic** the difference, if any, between the total amount of charges on my account and the amount paid by the attorney and/or insurance carrier. It is further understood that I, the undersigned, agree to pay **Movement Clinic** the full amount of charges on my account should my condition be such that it is not covered by my policy or if for any reason the insurance carrier refuses to pay my claim.

Patient Signature: _____ Date: _____

Printed Name: _____

Witness Signature: _____