

AUTOMOBILE ACCIDENT HISTORY

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

Address: _____

City: _____ State: _____ Zip: _____

SS#: _____ Driver's License #: _____

Insurance Company: _____ Name of Agent: _____

Address of Insurance Company: _____

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: _____ A.M. P.M.

State how accident happened in you 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: _____

(over)

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

Was your car hit? Front Back Left Side Right Side What damage was 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 the vehicle prior to the accident? _____

Do you have pictures of the involved automobile? Yes No 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: _____ County: _____ State: _____

Who was ticketed? _____ For what? _____

Did your vehicle strike anything? Yes No If yes, Another car Sign Tree Bridge Hedge

An 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

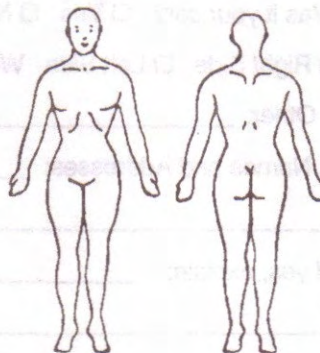
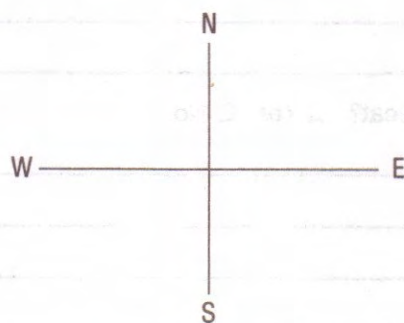
If so, Into a ditch? An Embankment? How Deep? _____

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 What type? _____



MARK PAIN AREA
+++ Burning
000 Stabbing
--- Sharp
||| Constant

PLEASE DRAW THE ACCIDENT

Patient Signature

Date

Staff Signature