

AUTOMOBILE ACCIDENT HISTORY

Name: _____ Age: _____ Date of Birth: _____ M F
Address: _____
City: _____ State: _____ Zip: _____
SS# _____ Drivers License# _____
Insurance Company: _____ Name of Agent _____
Insurance Company Address: _____
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? _____

ACCIDENT HISTORY:

Date of Accident: _____ Time of Accident: _____ A.M P.M.
State how 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? _____
Were you a passenger? _____ Front Back Right Side Left Side
Were you rotated in the seat? Yes No Were you reclined? Yes No
Were there other people in the car? Yes No Names and Addresses: _____

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

Seat belts on? Yes No Shoulder harness on? Yes No Position of headrest _____
Was it: Daylight 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 : Two Lane Four Lane Gravel Tar
Did the accident 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, where 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 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: _____

Were you completely conscious after the impact? Yes No

Do you remember the impact? Yes No Did your vehicle go off road? Yes No

If so, Into a ditch embankment How far/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? _____

PLEASE DRAW THE ACCIDENT:

Patient Signature

Date