

AUTO ACCIDENT HISTORY

Name: _____ Today's Date: ____/____/____ Date of Accident: ____/____/____

INFORMATION ABOUT THE MOTOR VEHICLE ACCIDENT:

City where the accident occurred: _____

Were you the: () Driver () Passenger () Pedestrian

Were you struck from the: () Front () Rear () Left Side () Right Side

Were you aware of the collision prior to impact or did it catch you by surprise? () Aware () Unaware

What position was your head facing during impact? () Forward () Left () Right () Other

Were you wearing a seatbelt with a shoulder harness? () Yes () No () Lap Belt Only () Unknown

Head Restraint: () None () Adjustable () Up () Down () Seatback Only () I don't know

Did the airbags deploy? () Yes () No If yes, were you struck by the airbags? () Yes () No

Road Conditions were: () Dry () Wet () Icy () Snow

Did the police show up at the scene? () Yes () No

Who was at fault? () Driver of the other vehicle () Driver of my vehicle () Myself () I don't know

Please describe the accident in as much detail as possible (ie: rear ended, side swiped, head-on, etc.):

Did you receive any visible cuts or bruises as a result of the accident? () Yes () No

If yes, where?

Did you strike any parts of your body on the interior of the vehicle? () Yes () No

If yes, explain.

Following the collision, did you experience: () Dizziness () Nausea () Confusion/ Disorientation () Headaches

Did your pain begin: () Immediately () Hours Later () Days Later () Other _____

INFORMATION ABOUT THE VEHICLE YOU WERE IN:

Year: _____ Make: _____ Model: _____

What was the estimated speed of your vehicle during impact: _____

Was your vehicle: () Slowing Down () Accelerating () Steady Speed () Stopped () Parked

Was your vehicle pushed forward after impact? () Yes () No If Yes, how much? _____

Did your vehicle strike any objects after the crash? _____

Estimated amount of damage to your vehicle: \$ _____

Estimated damage to the other vehicle? () None () Minimal () Moderate () Major

INFORMATION ABOUT OTHER VEHICLE(S) INVOLVED IN THE ACCIDENT:

Year: _____ Make: _____ Model: _____

What was the estimated speed of your vehicle during impact: _____

Was your vehicle: () Slowing Down () Accelerating () Steady Speed () Stopped () Parked

If more than one other vehicle was involved, please explain:

HOSPITAL EMERGENCY ROOM QUESTIONS:

Were you taken to a hospital/emergency room after the accident? () Yes () No

Date taken to the hospital (if not the same day): ____/____/____

Name of the hospital/emergency room: _____ City: _____

How did you get to the hospital? () Ambulance () Yourself () Someone else drove you

Were x-rays taken? () Yes () No

If Yes, were you () Laying Down () Standing Up () Seated

Which areas of your body were x-rayed? () Neck () Mid Back () Lower Back () Other _____

Was any treatment administered at the hospital? () Ice () Heat () Cervical Collar () Medication\

FOLLOW UP INSTRUCTIONS:

OTHER HEALTH CARE PROVIDERS SEEN AFTER THE ACCIDENT:

1. Dr. _____ Specialty: _____ Referred by: _____

Date first seen: ____/____/____ Treatment type: _____

Treatment Frequency/duration: _____ Currently Treating? () Yes () No Any

Disabilities? () Yes () No If yes, please describe: _____

Special Tests: (ie: xrays, CT Scan, MRI, etc...) _____

Did the treatments help? () Yes () No

2. Dr. _____ Specialty: _____ Referred by: _____

Date first seen: ____/____/____ Treatment type: _____

Treatment Frequency/duration: _____ Currently Treating? () Yes () No Any

Disabilities? () Yes () No If yes, please describe: _____

Special Tests: (ie: xrays, CT Scan, MRI, etc...) _____

Did the treatments help? () Yes () No

QUESTIONS ABOUT YOUR HEALTH AND SOCIAL HISTORY:

What is your occupation? _____

Employer at time of injury? _____ Phone Number: _____

Employer's address: _____

Was this accident an on the job injury? () Yes () No If yes, have you reported it to your employer? () Yes () No

Has the on the job injury been filed? () Yes () No If yes, what is the claim number? _____

Have you lost time from work as a result of the injury? () Yes () No If yes, please list dates: _____

Date returning to work or expected to return: _____

I am currently working: full time / part time (pls. circle one) _____

_____(hrs)(regular duty / light duty)\

PLEASE CHECK THOSE ACTIVITIES THAT ARE REQUIRED OF YOU AT WORK:

	Lifting		Occasionally		Frequently		Constantly	Up to _____ lbs
	Carrying		Occasionally		Frequently		Constantly	Up to _____ lbs

Pushing	Occasionally	Frequently	Constantly	Up to _____ lbs
Pulling	Occasionally	Frequently	Constantly	Up to _____ lbs
Sitting	Occasionally	Frequently	Constantly	
Standing	Occasionally	Frequently	Constantly	
Walking	Occasionally	Frequently	Constantly	
Bending	Occasionally	Frequently	Constantly	

Reaching	Occasionally	Frequently	Constantly	
Twisting	Occasionally	Frequently	Constantly	
Computer Work	Occasionally	Frequently	Constantly	

PLEASE CHECK THOSE ACTIVITIES THAT CAUSE WORSENING OF YOUR ACCIDENT RELATED INJURY:

Lifting	Sitting	Twisting	House Work	
Carrying	Standing	Reaching	Yard Work	
Pulling	Walking	Exercising	Driving	
Pushing	Bending	Computer Work	Other _____	

Signature: _____ **Date:** _____