AUTOMOBILE ACCIDENT HISTORY

(Circle all that apply)

Have you retained an attorney? **Yes** **No**

Name and phone number of Attorney: ____

General Symptoms:

Did you hit part of your body during the collision? For example: head on headrest or window, face on airbag, chest on steering wheel,

arm on door, knee on dashboard, etc? **Yes** **No**

If yes, which part and where? ____

Seat belts on? **Yes** **No** Shoulder harness on? **Yes** **No** Did the airbags inflate? **Yes** **No**

Did you end up with any bruises? **Yes** **No** If yes, where? ____

Did you go to the Hospital after the accident? **Yes** **No** Name of hospital? ____

If yes, when did you to the hospital? **That day** **Next day** **2 days plus**

What treatment did you receive? **X-rays** **MRI** **Prescriptions** Other: _______________________________________

Accident History:

Date of Accident: _________________________ Time of Accident: _________________ A.M. P.M.

State how the Accident happened in your own words:

____

____

What type of vehicle were you in? Make/Model/Year: ____

Were you driving? **Yes** **No** Was it your car? **Yes** **No** If not, whose? _____________________________________

Passenger? **Front** **Back/right or left** Which way were you facing at impact? **Forward** **Right** **Left**

Were you braced for the impact? **Yes** **No** If yes, did you brace with: **Hands** **Feet**

Other people in car? **Yes** **No**

Names and Addresses:

____

____

Were they injured? **Yes** **No**

If yes, please explain: ____

____

What were the weather conditions? ______________________________ What was the posted speed limit? ________________________

What were the traffic conditions? ___________________________________ How fast were you going? _______________

Did it happen at a/an: **Stop Sign** **Traffic Light** **Intersection** **Highway** **Other:** ______________________________

Was your car hit? **Front** **Back** **Left Side** **Right Side**

What damage was done to your car?

Inside: ____

Outside: ____

Other: ____

Did your vehicle strike anything? **Yes** **No** If yes: **Another car** **Sign** **Tree**

Other: _____________________________________

If you struck another car or object, where did you strike it? **Front** **Back** **Side** **Corner**

What was the damage to the other car?

Inside: ____

Outside: ____

Do you have pictures of the involved automobile(s)? **Yes** **No**

Was an accident report made? **Yes** **No** Police of: **City:** _______________________ **State:** ________________

Who was ticketed? _________________________ For what? ____

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**

How did you feel immediately after the accident? **Dizzy** **Disoriented** **Nervous** **Nauseous** **Upset** **Weak** **Scared**

Other: ____

When did the pain begin to appear? **Immediately** **Few hours later** **Few days later**

Have you had any time loss from work? **Yes** **No** If yes, from ________________________to _________________________

Are you work activities restricted as a result of this accident? **Yes** **No**

While in recovery, is there any light duty work you could request? **Yes** **No**

The above information is accurate and has been completed to the best of my knowledge:

Patient Signature: ____ Date: __________________________________