

# 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? \_\_\_\_\_

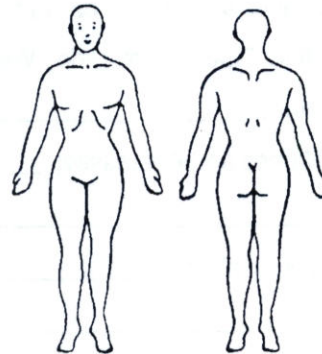
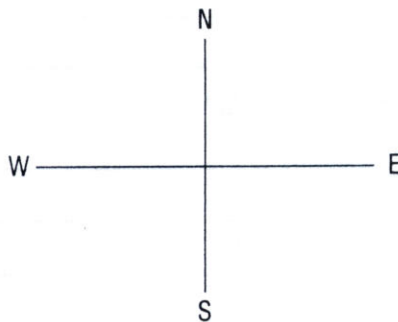
Does it bother you to ride in a car now?  Yes  No If so, as a  Driver  Passenger

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