Accident History

Name: ______________________ Age: _____ Date of Birth: __________________

□ male □ female

Date of Accident: ________ Hour: _____ □ Am □ Pm

Location: ____

ACCIDENT HISTORY □ Auto Injury □ Work Injury □ Other injury

Please describe the accident in detail:

____

____

____

____

(Example: Which direction were you heading and what road were you on?)

What kind of car were you in? ______________________ (year, make, model)

What kind of car hit you? ______________________ (year, make, model)

What is the property damage to your vehicle? □ Mild □ Moderate □ Severe

If you have had an estimate or your car repaired how much was it?

____

Were there any other passengers in the vehicle? If so who: ______________

Did anyone witness the accident? □ Yes □ no

Did you report the injury to your employer? □ Yes □ no

Were you: □ Driver □ Passenger □ Front seat □ Back seat □ Pedestrian

Were you struck from: □ Behind □ Front □ Left side □ Right side □ Vehicle Stopped

Did you see the accident coming? □ yes □ no

What direction were you headed: ______________________

Name of street you were on: ______________________

Did your vehicle strike another vehicle? □ Yes □ no

Did their vehicle strike your vehicle? □ yes □ no

Did the driver of your vehicle get a ticket: □ yes □ no

Did the driver of the other vehicle? □ yes □ no

Were you wearing your seat belt? □ yes □ no

What position was your headrest at the time of impact? □ high □ medium □ lower

Were the police notified? □ yes □ no

Did you require hospitalization for these injuries? □ yes □ no

Have you been treated by a family doctor or E.R since the accident? □ yes □ no Please give the name and address of the treating doctor:

____

What type of treatment did you receive?

____

GENERAL SYMPTOM Are your symptoms: □ better □ same □ getting worse

Please describe your symptoms in detail:

____

____

Do you notice any activity restrictions as a result of this injury? □ yes □ no If yes please describe in detail:

____

____

Check symptoms you have noticed since the accident: □ Headache □ Neck pain □ Neck stiff □ Back pain □Nervousness □ Tension□ Sleeping problems □ Dizziness □ Irritability □ Chest pain □ Head seems heavy □ Pins & needles in arms □ Pins & needles in legs □ Numbness in fingers □ Numbness in toes □ Depression □ Fatigue □Shortness of breath □ Lights bother eyes □ Loss of memory □ Ringing in ears □ Face flushed □Loss of memory □Fainting □ Loss of smell □ Loss of taste □ Diarrhea □ Feet cold □ Hands cold □ Stomach upset □ Constipation □Cold sweats □ Fever □
Other______________________________

GENERAL INFORMATION Have you lost any days from work as a result of this accident? □ yes □ no

Type of employment? ____________________ Dates missed? ____________________

Your insurance company name and address: ______________________________

Insurance company of the person responsible for your injuries: ______________________________

Have you been contacted by an insurance adjuster or company representative regarding this claim? □ yes □ no

Do you have an attorney that has advised you in this case? □ yes □ no

Attorney Name: ______________________________

Attorney address: ______________________________

Attorney telephone: ______________________________

____________________ ______________________________

Date Patients Signature