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 □Motocycle □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