Automobile Accident History

Name: _____ Date and time of accident: _____

Location of accident (city, state, street): _____

Road condition: □Wet □Dry □Snow/Ice □Other: _____

Were police notified of the accident? □Y □N Was a report filed? □Y □N □Unknown

Collision involved: □1 vehicle □2 vehicles □3 or more vehicles □pedestrian □Other:_____

Driver of car: _____ Where were **you** seated? □Driver □Front passenger □Rear left □Rear right □Rear middle

Other occupants in the car and their injuries: _____

Were you struck from: □Behind □Front □Left side □Right side □Other: _____

Were you aware of the collision before impact? □Y □N Did you brace for impact? □Y □N

Were you wearing a: □Seatbelt □Shoulder harness □None Did the airbag deploy? □Y □N

Year/make/model of car you were in: _____ Estimated damage: _____

Was it drivable? □Y □N What car parts were damaged? _____

Was your car moving at the time of collision? □Y □N If yes, how fast? _____ MPH

Was the driver of your car braking? □Y □N If no, was the drivers foot on the brake? □Y □N

Year/make/model of the other car: _____ Damage: □Mild □Mod □Severe Drivable: □Y □N

Was the other car moving at time of condition? □Y □N If yes, were they: □Slowing down □Gaining speed □Traveling at a steady speed

Describe how the accident happened:

_____

_____

Did you go to the hospital afterwards? □Y □N If yes, which hospital? _____

If yes, did you go: □Same day □Next day □Other:_____ How did you get there? _____

Were you examined by a doctor? □Y □N Were X-rays taken? □Y □N Body parts x-rayed:_____

What did the doctor say was wrong? _____

Treatment given: _____ Medications given: _____

Describe where you felt pain or unusual feelings:

a) During the accident: _____

_____

b) Immediately after the accident: _____

_____

c) Later that day/night (and up till now): _____

_____

→

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Was your head pointed: □Straight forward □Turned to the left □Turned to the right

Did you lose consciousness: □Y □N If yes, for how long? _____ If no, were you dazed or confused? □Y □N

Did you experience a flash of light or an explosion in your head? □Y □N

Did you receive any injuries/bruises/cuts from the seatbelt, airbag or from hitting something in the car? □Y □N

Check the symptoms you have experienced since the accident:

□Headache	□Ringing/buzzing in ears	□Sleeping problems	□Diarrhea/constipation
□Neck pain/stiffness	□Loss of smell/taste	□Numbness in toes	□Stomach upset/pain
□Mid back pain	□Loss of memory	□Numbness in fingers	□Shortness of breath
□Low back pain	□Fatigue	□Pins & needles in arms	□Blood in urine
□Jaw pain	□Tension	□Pins & needles in legs	□Chest pain
□Shoulder/arm/wrist pain	□Difficulty concentrating	□Cold hands/feet	□Depression
□Hip/leg/knee/ankle pain	□Dizziness/loss of balance	□Restlessness	□Nervousness/anxiety
□Eyes sensitive to light	□Forgetfulness	□Head feels too heavy	□Other:_____

Since this injury, are your symptoms: □Improving □Getting worse □Staying about the same

When are your symptoms the worst? □Morning □Afternoon □Evening □Night

Are your work activities restricted because of your injuries? □Y □N Last date worked: _____

Have you lost time from work as a result of the accident? □Y □N Explain: _____

Describe your work duties: _____

How did you feel before the accident? _____

Ongoing conditions/complaints experienced before accident: _____

Have you injured this are of your body before? □Y □N If yes, explain: _____

If you have been in any other auto or work accidents please list the year and describe briefly:

1) _____
2) _____

Have you seen any other doctors as a result of this accident? □Y □N If yes, by whom?_____

What was the treatment (if any)? _____ Did it help? □Y □N

Are you pregnant? □Y □N Date of last menstrual period? _____

Have you consulted an attorney? □Y □N Name: _____

Patient's Signature: _____

Parent/Guardian's Signature (if under 18): _____

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