AUTOMOBILE ACCIDENT HISTORY

AUTOMOBILE ACCIDENT:

Name _____ Sex M / F Age: _____

Address _____ Driver's License # _____

GENERAL SYMPTOMS:

Did you hit any part of your body during the collision, for example, head on the dash, chest on steering wheel ? Y / N

If Yes, which part and how? _____

Where you taken after the accident? _____

Were you hospitalized? Y / N When did you go? _____ If yes, how did you get there? _____

If by ambulance, did the ambulance attendants place you in a ____ neck brace ____ back brace ___ other_____

Any medications or medical supplies given? _____

Did you have x-rays, CT, MRI taken? Y / N When? _____ Where? _____

How long were you there? _____

Did you receive care from any other health care specialist? Y / N ? If yes , who? _____

What type of care were you given and for how long? _____

Immediately after the accident were you ____conscious ____ dazed/confused ___unconscious
If unconscious for how long? _____

Where did you feel the pain initially? _____ 72 hours later?_____

What are your current symptoms? _____

Have you ever been injured in a similar manner? Y / N If yes, how and when? _____

_____

ACCIDENT HISTORY:

Date and Time: _____

State How Accident Happened in your own words_____

_____

_____

Were you driving? Y / N Passenger? Y/ N Pediatrian? Y / N
Was it your car? Y / N If not who's car was it? _____

Passenger? Y / N Were you in the Front? Back? right middle or left side? _____

At the time of impact were you: ____looking straight ahead ____ looking to the right ____ looking to the left
___ looking down ____ looking up

AUTOMOBILE ACCIDENT HISTORY(cont.)

Was your vehicle shoved: ___ forward ____ backward ___sideways

Did your vehicle hit: _____another car ____ a sign __ guard rails ___ bridge ___other _____

Were you shoved: ____ forward ___backward ___sideways

Did your seat have a head restraint(headrest?) Y / N If yes, what position: ____low _____midposition _____high

Did your head ride over the headrest? Y / N Did your hat/glasses end up in the back seat or rear window? Y / N

Did any other part of your body hit the interior of the vehicle? Y/ N if yes please specify: ____ seatbelt restraints

___ steering wheel ___ dashboard ___ windshield ___side door ___ side window ___ other _____

Were you holding the steering wheel? Y / N Did you brace your arms Y/ N ____steering wheel ___ dash

Were you surprised by the impact? Y / N

Did you brace your legs against the floorboard? Y /N Was your ankle turned? Y / N

Did the vehicle go into a spin or roll as a result of the impact? Y / N
How much damage to the outside of your vehicle? _____ none _____ some ___ a lot ___ totaled
How much damage to the other vehicle? _____ none _____ some ___ a lot ___ totaled
Other people in car: Name and Address: _____
_____
_____

Other vehicle ? __ car ___ truck __ motorcycle ___ other _____

Who was ticketed? _____ why? _____

Seat Belt On? Y / N Shoulder harness on? Y / N Did the seat belt break? Y/ N Did it contribute to your pain? Y/N

Was it daylight, night, dusk or dawn? _____

Were you tired? Y / N Were you awake? Y / N How long had you been in the car? _____

Where were you prior to the accident? _____ What was the weather conditions? _____

_____ Traffic conditions? _____

What was the posted speed limit? _____ How fast were you going? _____ The other car? _____

Was your vehicle in: ___ park ___ neutral ___ in gear ___ moving ___ stopped

Were your brakes being applied? Y / N

Type of Road: Two Lane _____ Four Lane ____ Gravel _____ Tar ____ One Way _____ Divided _____

Did it happen at: _____ a stop sign? _____ traffic light? _____ at an intersection? ___ other? _____

Was your car hit? ___Front __ Back __Left side front ___Left side Back ___Right side front ___Right side back

What damage was done to your car? Inside _____

Outside_____

Other_____

AUTOMOBILE ACCIDENT HISTORY(cont.)

If you struck another car, did you strike it: ____Front ____ Back ___Side

What was the damage to the other car? Inside _____

Outside _____

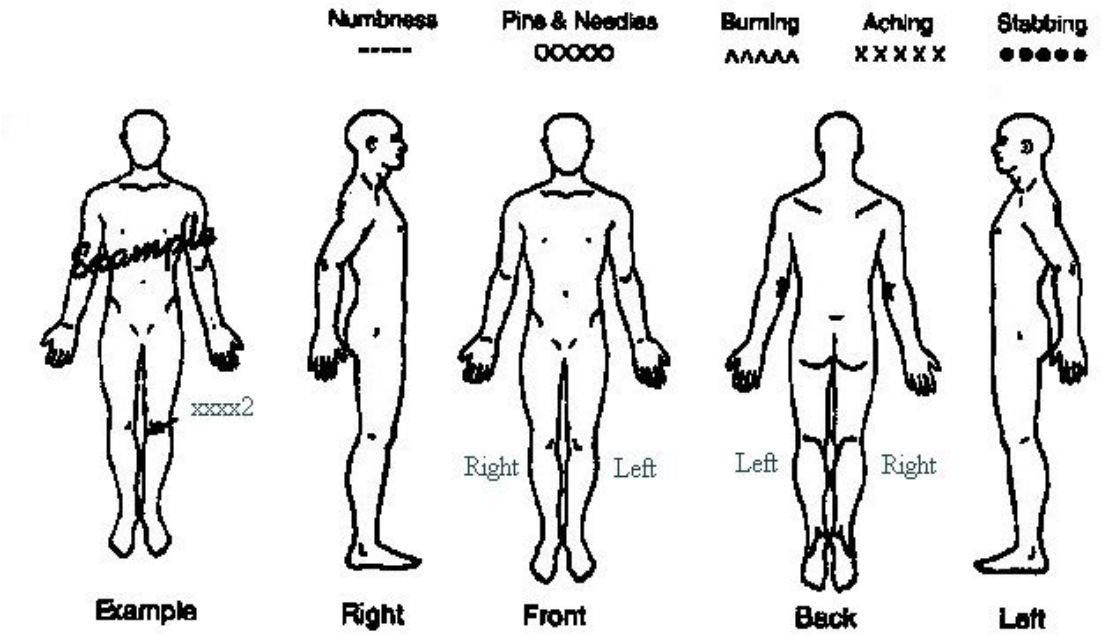
Have you lost time from work? Y / N If yes how long? _____ Does it bother you to ride in a car now? Y/ N

ATTORNEY INFORMATION

Do you have an attorney: Y / N If yes: Name, address and phone number: _____

_____

Please fill out the diagram as you feel currently



Patient Signature: _____ Date: _____

Print Name : _____

Witness: _____ Date: _____