Motor Vehicle Accident History

PATIENT NAME:			DATE:
ADDRESS:		CITY:	STATE/ZIP CODE:
HOME PHONE NUMBER:		CELL PHONE NUMBER:	
SOCIAL SECURITY NUMBER:	DATE OF BIRTH:	AGE:	GENDER:
EMERGENCY CONTACT NAME:		EMERGENCY CONTACT PHONE NUMBER:	
EMPLOYER NAME:		EMPLOYER ADDRESS:	

ACCIDENT INFORMATION

DATE OF ACCIDENT:	TIME OF ACCIDENT:	WHERE WERE YOU LOCATED IN THE VEHICLE AT THE TIME OF THE ACCIDENT? ❑ DRIVER ❑ PASSENGER ❑ FRONT SEAT ❑ BACK SEAT
PLEASE DESCRIBE THE ACCIDENT IN YOUR OWN WORDS:		
NUMBER OF PEOPLE IN THE CAR:	NAMES OF PEOPLE IN THE CAR WITH YOU:	

DID YOU GO TO THE HOSPITAL? ❑ YES ❑ NO	HOW DID YOU GET TO THE HOSPITAL? ❑ AMBULANCE ❑PRIVATE
WHEN DID YOU GO? ❑ IMMEDIATELY AFTER ACCIDENT ❑ NEXT DAY ❑ 2 DAYS OR MORE AFTER THE ACCIDENT	
NAME OF HOSPITAL	NAME OF DOCTOR
DIAGNOSIS	
TREATMENT RECEIVED X-RAYS TAKEN: ❑ YES ❑ NO	
HAVE YOU BEEN TREATED BY ANY OTHER DOCTORS FOR THIS ACCIDENT? ❑ YES ❑ NO	SINCE THE INJURY, ARE YOUR SYMPTOMS: ❑ IMPROVING ❑ GETTING WORSE ❑ GETTING BETTER
HAVE YOU LOST TIME FROM WORK? ❑ YES ❑ NO	DATE YOU LEFT WORK: / DATE YOU RETURNED TO WORK:
HAVE YOU BEEN INVOLVED IN AN ACCIDENT IN THE PAST? ❑ YES ❑ NO	IF YES, PLEASE DESCRIBE:
DO YOU HAVE ANY PREVIOUS ILLNESSES WHICH RELATE TO THIS CASE? ❑ YES ❑ NO	IF YES, PLEASE DESCRIBE:
DO YOU HAVE ANY ACTIVITY RESTRICTIONS AS A RESULT OF THIS INJURY? ❑ YES ❑ NO	IF YES, PLEASE DESCRIBE:

ACCIDENT SITE	IMPACT
ROAD/STREET NAME	DID YOUR CAR IMPACT ANOTHER VEHICLE? ❑ YES ❑ NO
CITY/STATE	DID YOUR CAR IMPACT A STRUCTURE? ❑ YES ❑ NO IF YES, EXPLAIN:
NEAREST INTERSECTION WITH ROAD/STREET	DID ANY PART OF YOUR BODY STRIKE ANYTHING IN THE VEHICLE? ❑ YES ❑ NO IF YES, EXPLAIN:
DRIVING CONDITIONS: ❑DRY ❑WET ❑ICY ❑OTHER_____	WERE YOU KNOCKED UNCONSCIOUS? ❑ YES ❑ NO
WERE YOU STRUCK FROM: ❑ BEHIND ❑ FRONT ❑ LEFT SIDE ❑ RIGHT SIDE	WAS IMPACT FROM: ❑ FRONT ❑ REAR ❑ LEFT ❑ RIGHT ❑ OTHER_____
SPEED YOU/OTHER CAR WAS TRAVELING?	AT THE TIME OF IMPACT WERE YOU: ❑LOOKING STRAIGHT AHEAD ❑LOOKING TO THE RIGHT ❑LOOKING TO THE LEFT ❑LOOKING DOWN ❑LOOKING UP
DID YOU APPLY BRAKES?	
VEHICLE	WERE BOTH HANDS ON THE STEERING WHEEL? ❑ YES ❑ NO IF NO, WHICH HAND WAS ON THE WHEEL? ❑ RIGHT ❑ LEFT
MAKE AND MODEL OF VEHICLE YOU WERE IN:	
WERE YOU WEARING A SEATBELT? ❑ YES ❑ NO IF YES, WHAT TYPE? ❑ LAP ❑ SHOULDER	WAS YOUR FOOT ON THE BRAKE? ❑ YES ❑ NO IF YES, WHICH FOOT WAS ON THE BRAKE? ❑ RIGHT ❑ LEFT
WAS VEHICLE EQUIPPED WITH AIRBAGS? ❑ YES ❑ NO IF YES, DID THEY INFLATE PROPERLY? ❑ YES ❑ NO	WERE YOU: ❑SURPRISED BY IMPACT ❑BRACED FOR IMPACT
DID YOUR SEAT HAVE A HEADREST? ❑ YES ❑ NO IF YES, WHAT WAS THE POSITION OF THE HEADREST? ❑ LOW ❑ MIDPOSITION ❑ HIGH	

INSURANCE INFORMATION	
AUTO INSURANCE COMPANY NAME:	BILLING ADDRESS:
ADJUSTER NAME:	CLAIM NUMBER:
PHONE NUMBER:	
POLICY NUMBER:	

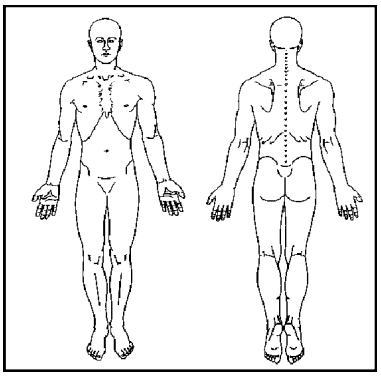
INSTRUCTIONS: *CHECK (✓) ANY/ALL SYMPTOMS NOTED AFTER THE ACCIDENT.*

- ❑ HEADACHE
- ❑ NECK PAIN
- ❑ NECK STIFFNESS
- ❑ SLEEPING PROBLEMS
- ❑ BACK PAIN
- ❑ BACK STIFFNESS
- ❑ NERVOUSNESS
- ❑ TENSION
- ❑ IRRITABILITY
- ❑ CHEST PAIN
- ❑ DIARRHEA
- ❑ CONSTIPATION
- ❑ FEVER
- ❑ ARM/SHOULDER PAIN
- ❑ DIZZINESS
- ❑ HEAD SEEMS HEAVY
- ❑ PINS & NEEDLES IN ARMS
- ❑ PINS & NEEDLES IN LEGS
- ❑ NUMBNESS IN FINGERS
- ❑ NUMBNESS IN TOES
- ❑ SHORTNESS OF BREATH
- ❑ FATIGUE
- ❑ DEPRESSION
- ❑ FEET FEEL COLD
- ❑ HANDS FEEL COLD
- ❑ COLD SWEATS
- ❑ JAW PROBLEMS
- ❑ LEG PAIN
- ❑ LIGHT BOTHERS EYES
- ❑ LOSS OF MEMORY
- ❑ EARS RING
- ❑ FACE FLUSHED
- ❑ BUZZING IN EARS
- ❑ LOSS OF BALANCE
- ❑ FAINTING
- ❑ LOSS OF SMELL
- ❑ LOSS OF TASTE
- ❑ UPSET STOMACH
- ❑ VISION BLURRED
- ❑ OTHER: _____
- ❑ OTHER: _____

IS THIS CONDITION GETTING PROGRESSIVELY WORSE? ❑ YES ❑ NO

INTRUCTIONS: *Please mark the area and type of pain on the drawings using the codes listed below:*

N=Numbness P=Pain A=Ache T=Tingling S=Stiffness/Soreness



COMMENTS:

RATE THE SEVERITY OF YOUR PAIN ON A SCALE FROM 1 (LEAST PAIN) TO 10 (SEVERE PAIN)

1	2	3	4	5	6	7	8	9	10

HOW OFTEN DO YOU HAVE THIS PAIN?_____

IS IT CONSTANT OR DOES IT COME AND GO? _____

DOES IT INTERFERE WITH YOUR: ❑WORK ❑SLEEP ❑DAILY ROUTINE ❑RECREATION

ACTIVITIES OR MOVEMENTS THAT ARE PAINFUL TO PERFORM: ❑SITTING ❑STANDING ❑BENDING ❑LYING DOWN

PLEASE PROVIDE ANY OTHER PERTINENT INFORMATION YOU THINK WE SHOULD KNOW:

DOCTOR ONLY

DOCTOR COMMENTS:

SIGNATURE

PATIENT SIGNATURE:	DATE:

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