Automobile Accident History

Date: _____
Patient Name: _____Date of Birth: _____
Date of Accident: _____Time Accident Occurred: ____AM/PM
City Where Accident Occurred: _____
Street: _____
Road conditions at the time of the accident: Wet Dry Icy Other: _____
Were the police at the scene of the accident? Yes No
Was a report filed? Yes No
Were you taken to the hospital? Yes No Which One? _____
Were you required to stay in the hospital as a patient? Yes No
What is the name of the doctor that treated you after the accident? _____
If you were seen in a hospital/clinic, were x-rays taken at that time? Yes No
If YES, what X-rays were taken? Head Shoulders Neck Back Arm(s) Leg(s)
Pelvis Feet Hand(s)
If you have been in a previous auto accident(s) - list the year of the accident(s):
1. _____2._____3._____4._____
Have you retained an attorney? Yes No His/Her name: _____

The following questions pertain to you, the patient, and the vehicle you were in:

- What type of accident was this? Head-on Rear-ended Side Impact
- Where were you seated in the vehicle?_____
- Was the trunk of your body pointed straightforward at the time of impact?_____
- If no, which direction was it turned, and how much? _____
- Was your head pointed straightforward at the time of impact?_____
- If no, which direction was it turned, and how much? _____
- What were you doing at the time of impact? _____
- Were you aware of the approaching collision prior to impact or did it catch you by surprise? _____
- Did you lose consciousness? Yes No
- If yes for approximately how long? _____
- Was anyone else in your car injured in the accident? _____
- How far is the top of the headrest or the car from the top of your head?
  Approximately_____inches above or below (circle one)
- Were you wearing a seatbelt? Yes No Type: Lap Shoulder-Lap Were airbags engaged? Yes No

Patient Name: _____

- What is the Year_____, Make_____, Model_____ of the car you were in?
- Was your car stopped at the time of impact? Yes No
- Was the driver's foot on the brake? Yes No
- If the car you were in was moving, estimate the speed of the vehicle at the time of the accident:_____
- Was the car: (Circle One) Slowing down Gaining speed Steady rate
- On what part of the auto did the following body parts hit:
    1. Head _____
    2. Neck_____(right or left)
    3. Chest _____
    4. Shoulder_____(right or left)
    5. Arm_____(right or left)
    6. Upper Back_____(right, middle, or left)
    7. Lower Back_____(right, middle, or left)
    8. Hip_____(right or left)
    9. Leg_____(right or left)
    10. Other _____
- What is the cost of damage to the vehicle you were in? _____
- Which of the following car parts broke during the accident?:
    1. Windshield _____
    2. Side Window (right or left) (front or back)
    3. Steering Wheel_____
    4. Seats (right or left) (front or back)
    5. Doors (right or left) (front or back)
    6. Bumpers (front or back)
    7. Other_____
    8. None
- Were you on the job at the time of injury? Yes No
- Were you unable to work due to injuries sustained? Yes No How long? _____
- What day did you return to work?_____Full-time Part-time
- Any restrictions? _____
- What symptoms were you experiencing prior to this accident? _____

The following questions pertain to the other vehicle involved in the accident:

- What is the Year_____, Make_____, Model_____ of the other car?
- Was the other car moving at the time of impact? Yes No
- Estimate the speed of the other vehicle: _____
- Was the other driver or any passengers injured in this accident?
  Yes No Unknown

Patient Description of Automobile Accident

Patient Name:_____ Date:_____

Explain in your own words exactly how this accident occurred; what you felt as it happened, and how you have felt since. It is important that you describe all activities related to this accident including any emergency help such as paramedics, police, bystanders, etc., that may have assisted. Please use details and be specific, as no fact is too small to mention.

Automobile Accident Insurance Information

Patient Name:_____ Date:_____

1. Were you involved in an automobile accident? Yes ___ No ___
2. If so, date of accident _____
3. Who was issued at fault? You ___ Other Party____

Please give us your automobile insurance information:

Agent's name _____
Name of automobile insurance company _____
Address _____
Policy # _____ Claim # _____
Phone # _____

Name of insured **(if different from the patient)** _____
Do you carry uninsured coverage on your policy? Yes ___ No ___
Do you carry "medical payment coverage"? Yes ___ No ___ If so, what is the amount? _____

Please give us other involved parties automobile insurance information:

Name _____
Agent's name _____
Name of automobile insurance company _____
Address _____
Policy # _____ Claim # _____
Phone # _____

Please give us your health insurance information:

Company Name _____
Address _____
Policy # _____ Claim # _____
ID # _____ Group # _____
Insured Name _____
DOB _____ SSN _____

Please attach copy of the automobile accident report