



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