Auto Accident History

Name ____ Date of Birth __________________

Your Insurance Co. ___________________________ Claim # ______________________________

Your Ins. Co.'s Phone # __________________ Agent ________________ Policy # ______________

Other driver _______________________________ Other driver's Ins. Co. ____________________

Claim # _________________________ Agent _________________ Policy # _________________

Have you retained an attorney? ( ) Yes ( ) No Name _____________________________

Were there any witnesses? ( ) Yes ( ) No Name(s) ___________________________

Nature of the accident:

Date of accident ______________________ Time of day ____________________________

Were you ( ) Driver ( ) Passenger ( ) Front seat ( ) Back seat

Number of people in your vehicle? _____ Other vehicle? _____

What direction were you headed? ( ) North ( ) South ( ) East ( ) West

on (name of street) ____

What direction was the other vehicle headed? ( ) North ( ) South ( ) East ( ) West

on (name of street) ____

Were you struck from ( ) Behind ( ) Front ( ) Left side ( ) Right side

Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long? _______________

Were the police notified? ( ) Yes ( ) No

In your own words, please describe the accident: ____

____

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After the accident, you ____

____

Did you have any physical complaints BEFORE THE ACCIDENT? ( ) Yes ( ) No

If yes, please describe in detail: ____

____

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Please describe how you felt

DURING the accident ____

IMMEDIATELY after ____

LATER THAT DAY ____

THE NEXT DAY ____

What are your PRESENT complaints and symptoms? _______________________________________

____

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Do you have any congenital (from birth) factors that relate to this problem? ( ) Yes ( ) No

If yes, please describe: ____

____

Do you have any previous illnesses that relate to this problem? (   ) Yes   (   ) No

If yes, please describe: ______________________________

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Have you ever been involved in an accident before? (   ) Yes   (   ) No

If yes, please describe, including the date(s) and type(s) of accidents as well as injuries received: ______________________________

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Have you been treated by another doctor since this accident? (   ) Yes   (   ) No

If yes, please list doctor's name and contact # ______________________________

What type of treatment did you receive? ______________________________

____

Since the accident, are your symptoms (   ) improving   (   ) the same   (   ) getting worse

Check any symptoms you have noticed since the accident

- □ Headache
- □ Neck Pain
- □ Mid-back Pain
- □ Low back Pain
- □ Chest Pain
- □ Leg Pain
- □ Arm Pain
- □ Irritability
- □ Trouble Concentrating
- □ Memory Loss
- □ Pins and Needles
- □ Shortness of Breath
- □ Cold Sweats
- □ Buzzing/ Ringing in Ears
- □ Loss of Balance
- □ Upset Stomach
- □ Fatigue
- □ Sleeping Problems
- □ Cold Hands or Feet
- □ Dizziness
- □ Loss of Taste

Have you lost time from work/ school as a result of this accident? (   ) Yes   (   ) No

If yes, last day worked ______________________________

Type of employment ______________________________

Are you being compensated for the lost time? (   ) Yes   (   ) No

If yes, what type of compensation are you receiving? ______________________________

Do you notice any activity restrictions as a result of this injury? (   ) Yes   (   ) No

If yes, please describe in detail: ______________________________

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Other pertinent information: ______________________________

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______________________________   ______________________________

Patient signature   Date