

# AUTOMOBILE ACCIDENT HISTORY FORM

Full Name \_\_\_\_\_ Today's Date \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Occupation \_\_\_\_\_  
Sex  M  F Marital Status  S  M  D  W Age \_\_\_\_\_ Birthday \_\_\_\_/\_\_\_\_/\_\_\_\_  
Race  Caucasian  African-American  Hispanic  Asian  Other \_\_\_\_\_ SS# \_\_\_\_\_

## HISTORY OF ACCIDENT (check all that apply)

1. Date of Accident \_\_\_\_\_ Time of Accident \_\_\_\_\_
2. Description of Accident \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
3. Location of Accident Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_
4.  Driver  Passenger  Pedestrian  Other \_\_\_\_\_
5.  Traveling  Stopped facing  N  S  E  W  Unknown Direction
6. **YOUR** Vehicle Type:  Compact  Midsize  Truck  Sport Utility  Van  Semi-truck
7. **OTHER** Vehicle Type(s):  Compact  Midsize  Truck  Sport Utility  Van  Semi-truck
8. Who was issued the citation?  Nobody, we exchanged insurance info  I was / My party  Other party
9.  Stopped and rear-ended  Moving and rear-ended  Slowing down to make stop / turn and rear-ended  
 Head-on collision – other vehicle traveling in opposite direction  Side swiped RIGHT / LEFT  Rolled over  
 Another vehicle ran stop sign / red light  Lost control of vehicle  Spun around  T-boned RIGHT / LEFT
10. If rear-ended, did the force of the impact cause your vehicle to collide with another vehicle?  Yes  No
11. Road conditions at the time of the accident:  Wet  Dry  Icy  Other \_\_\_\_\_
12. Approximate speed of **YOUR** vehicle: \_\_\_\_\_ mph
13. Approximate speed of **OTHER** vehicle: \_\_\_\_\_ mph
14. Were you wearing a seat belt?  Yes  No Were you aware of the impending collision?  Yes  No
15. How far is the top of the headrest or seatback from the top of your head? (measurement in inches)  
 0"  1"  2"  3"  4"  5"  6"  Other \_\_\_\_\_  Above  Below
16. Did you strike any objects in the car?  Yes  No
17. If yes, then what?  Steering column  Rearview mirror  Seat broke  Dashboard  
 Door frame  Headrest  Jarred or thrown about  Windshield  
 Cannot remember details (dazed)  Other \_\_\_\_\_
18. What portion of your body did you strike?  Head  Chest  Face  Arms  Hands  Legs  Knees  
 Shoulder  Hip  Other \_\_\_\_\_
19. As a result of the accident were you?  not injured  cut/bleeding  bruised  dizzy  nauseas  
 blurred vision  unconscious  ringing/buzz in ears  partially paralyzed  other \_\_\_\_\_
20. If cut, bruised, and/or partially paralyzed please explain where \_\_\_\_\_

21. If you experienced immediate pain, please indicate where:

- |  |                               |                                |  |                               |                                |
|--|-------------------------------|--------------------------------|--|-------------------------------|--------------------------------|
| <input type="checkbox"/> Headache        | <input type="checkbox"/> Left | <input type="checkbox"/> Right | <input type="checkbox"/> Neck pain     | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Upper-back pain | <input type="checkbox"/> Left | <input type="checkbox"/> Right | <input type="checkbox"/> Mid-back pain | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Chest pain      | <input type="checkbox"/> Left | <input type="checkbox"/> Right | <input type="checkbox"/> Low-back pain | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Arm             | <input type="checkbox"/> Left | <input type="checkbox"/> Right | <input type="checkbox"/> Elbow         | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Knee            | <input type="checkbox"/> Left | <input type="checkbox"/> Right | <input type="checkbox"/> Leg           | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| <input type="checkbox"/> Other _____     |                               |                                |  |                               |                                |

22. After the accident, did you?  go home  go to work  go about your business  go to the hospital

## HOSPITALIZATION

23. If taken to the hospital, how did you get there?  Ambulance  Driven by friend / relative  Drove yourself  Went later
24. If you went later, then when? \_\_\_\_\_ Name of hospital \_\_\_\_\_
25. Were you seen in the emergency room?  Yes  No
26. Were you admitted to the hospital?  Yes  No
27. If admitted, how long did you stay? \_\_\_\_\_
28. Name of admitting or hospital physician? \_\_\_\_\_
29. What was done in the emergency room or hospital?  Examination  Stitches  X-rays  Surgery  
 Physical Therapy  Casting  Cervical collar  Prescription(s) \_\_\_\_\_  
 Other \_\_\_\_\_
30. After being released, what did you do?  Return home to bed  Return to work  Return to the emergency room  
 Other \_\_\_\_\_
31. When did you first consult a physician?  Same day  Following day  Within a few days  
 Did not consult one  Other \_\_\_\_\_

### (If patient consulted this office, skip to PAST HISTORY)

32. Who did you consult? Dr. \_\_\_\_\_  Family Physician  Chiropractor  Orthopedist  
 Osteopath  Neurologist  Other \_\_\_\_\_
33. What did the doctor do?  Chiropractic manipulation  Examination  X-rays  Injections  Traction  
 Physiotherapy  Prescription(s) \_\_\_\_\_  Other \_\_\_\_\_
34. How long were you under this doctor's care? \_\_\_\_\_
35. Are you still under this doctor's care?  Yes  No
36. Frequency or number of visits now? \_\_\_\_\_
37. Did the doctor refer you to or have you been to any other physician?  Yes  No  
 If yes, explain: \_\_\_\_\_
38. Were you sent for an independent medical examination?  Yes  No  
 If yes, to whom? \_\_\_\_\_
39. Other pertinent information \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**PAST HISTORY**

40. Have you ever been in any previous accident of any kind?  Yes  No

If yes, please give dates and details \_\_\_\_\_

41. Were you rendered permanently impaired?  Yes what % \_\_\_\_\_  No

42. Has any other physician prior to this accident ever treated you for neck or back problems?  Yes  No

If yes, please explain \_\_\_\_\_

43. Have you had any previous surgeries or any conditions that I should know about?  Yes  No

If yes, please explain \_\_\_\_\_

44. Were you symptom free and in good health before this accident?  Yes  No

If no, please explain \_\_\_\_\_

**PRESENT COMPLAINTS**

45. Please list your current problem areas (prioritize with worst being #1)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_

46. Have you lost any time from work since the accident?  Yes  No

47. If yes, how many days? \_\_\_\_\_ Are you still off work?  Yes  No

48. Date returned \_\_\_\_\_ Job description \_\_\_\_\_

49. In what way have your injuries affected your ability to work? \_\_\_\_\_

50. Have your injuries affected your hobbies and/or recreational activities?  Yes  No

51. If yes, please explain. \_\_\_\_\_

49. If you have an attorney representing you, please give name, address, and telephone number:

Name \_\_\_\_\_ Firm \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_