



AUTOMOBILE ACCIDENT HISTORY

Patient Name: _____ **Date:** _____

BASIC INFORMATION

Today's Date _____/_____/_____		Date of Injuries _____/_____/_____	
Was the accident on the job? _____ Yes _____ No		Were you seated in the car? _____ Yes _____ No	
Name of the person driving the vehicle _____			
Your Vehicle: Make _____ Model _____ Year _____			
Your estimated speed at the time of the accident: _____ Mph _____ Stopped _____ Slowing			
_____ Accelerating		If stopped, was your foot on the brake? _____ Yes _____ No	
Other Vehicle: Make _____ Model _____ Year _____			
Estimated speed of the other vehicle at time of accident: _____ Mph _____ Stopped _____ Slowing			
_____ Accelerating			
Road conditions at the time of the accident: _____ Dry _____ Damp _____ Wet			
Time of day: _____ Dawn _____ Daylight _____ Dusk _____ Dark			

HEAD RESTRAINTS & SEAT BACKS

How far is the top of the headrest or seat back from the back of your head while sitting? _____ Inches	
If you have an adjustable headrest, was its position altered by the accident? _____ Yes _____ No	
Was the seat back adjustment altered by the accident? _____ Yes _____ No	
Was the seat broken? _____ Yes _____ No	

SEAT BELTS & AIR BAGS

Were you wearing a seat belt? _____ Yes _____ No _____ Don't Know	
What type of seat belt were you wearing? _____ Lap Belt _____ Shoulder Belt _____ Shoulder-Lap Belt	
Did your air bag deploy? _____ Yes _____ No	
If Yes, were you stuck? _____ Yes _____ No If Yes, Where? _____	

HEAD & BODY POSITION

Which way was your <u>body</u> positioned at the time of impact? _____ Straight _____ Right _____ Left	
Which way was your <u>head</u> positioned at the time of impact? _____ Straight _____ Right _____ Left	

ACCIDENT DIAGRAM (Please draw a diagram of the time of impact)

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STATEMENT (In the space provided below describe, to the best of your knowledge, what happened during the accident)

DURING THE CRASH

Position of hands: ___ One on the wheel ___ Two on the wheel ___ Neither on the wheel ___ N/A
 Did you strike any parts of the vehicle? ___ Yes ___ No If yes, Describe _____
 Did vehicle strike any objects after crash? ___ Yes ___ No If yes, Describe _____
 Were you aware or surprised of the approaching collision? ___ Aware ___ Surprised
 Were you wearing a hat or glasses? ___ Yes ___ No
 If Yes, were they still on after the crash? ___ Yes ___ No
 Did you lose consciousness (black out) upon impact? ___ Yes ___ No If Yes, How long? _____
 Did you experience a flash of light or explosion in your head? ___ Yes ___ No

AFTER THE CRASH

Did you become: ___ Confused ___ Disoriented ___ Light Headed ___ Dizzy ___ Nauseated
 ___ Ringing/Buzzing in Ears
 Do you still have any of these symptoms? ___ Yes ___ No If Yes, Which ones? _____
 ___ Restlessness ___ Irritable ___ Difficulty Concentrating ___ Difficulty with memory
 ___ Sleeplessness ___ Forgetful ___ Reduced tolerance to heat ___ Reduced tolerance to alcohol
 Did the police come to the accident scene? ___ Yes ___ No
 Was a report filed? ___ Yes ___ No

HOSPITAL

Did you go to the hospital? ___ Yes ___ No
 How did you get to the hospital? ___ Ambulance ___ Someone Else ___ Yourself
 Name and city of hospital _____
 Were x-rays taken at the hospital ___ Yes ___ No
 If Yes, what body parts were x-rayed? _____
 Were any other diagnostic tests (MRI, CT, Scan, etc.) performed? ___ Yes ___ No
 If Yes, Describe _____
 How long did you stay in the hospital? _____
 What did the hospital do for your injuries? ___ Ambulance ___ Someone Else ___ Yourself
 Follow up instructions _____

I understand and guarantee the information I have provided within is complete and correct to the best of my knowledge.

Patient
Signature _____

Date / /