Auto Accident/Personal Injury

NAME _____ DATE _____

History of Accident

Date of Accident _____ Time _____ ☐ AM ☐ PM Location _____
Describe the accident in your own words _____
_____
_____

Were you: ☐ Driver ☐ Passenger ☐ Pedestrian
What seat were you sitting in? ☐ Front: ☐ Driver ☐ Center ☐ Right
☐ Rear: ☐ Left ☐ Center ☐ Right
Who owns the vehicle? _____ Year, make and model of vehicle _____
Year, make and model of other vehicle _____

Road conditions at the time of the accident: ☐ Dry ☐ Wet ☐ Snow ☐ Icy
☐ Paved ☐ Gravel ☐ Dirt ☐ Other _____

Your vehicle was hit in the: ☐ Right ☐ Left ☐ Side ☐ Front ☐ Rear
Type of accident: ☐ Head-on collision ☐ Broad Side collision
☐ Rear-end collision ☐ Front impact, rear ended vehicle in front
☐ Non-collision: _____
Was there a police investigation at the scene? ☐ Yes ☐ No
Citation issued? ☐ Yes ☐ No To whom? _____
Were you pre-warned that the accident was about to happen? ☐ Yes ☐ No
Did you brace for the impact? ☐ Yes ☐ No
After the first impact, did your vehicle hit anything else? ☐ Yes ☐ No What? _____
Were your hands on the steering wheel? ☐ Yes ☐ No
Were lap belts worn? ☐ Yes ☐ No
Were shoulder harnesses worn? ☐ Yes ☐ No
Did the vehicle have headrests? ☐ Yes ☐ No
If yes, what was the position of those headrests compared to your head?
Top of headrest even with ☐ top of head ☐ bottom of head ☐ middle of neck

Was your vehicle moving at the time of the accident? ☐ Yes ☐ No
If yes, was your vehicle: ☐ Slowing down/braking ☐ Speeding up ☐ Constant speed
If no, was the driver's foot on the brake? ☐ Yes ☐ No
Was the other vehicle moving at the time of the accident? ☐ Yes ☐ No
If yes, was the other vehicle: ☐ Slowing down/braking ☐ Speeding up ☐ Constant speed

Head position at the time of impact: ☐ Straight ☐ Unknown
☐ Turned: ☐ Left ☐ Right ☐ Looking back
Body position at the time of impact: ☐ Straight ☐ Unknown
☐ Turned: ☐ Left ☐ Right ☐ Looking back
At the time of the accident, did you strike anything in the vehicle? ☐ Yes ☐ No ☐ Unknown
If yes, specify: ☐ Steering wheel ☐ Dashboard ☐ Windshield ☐ Side door ☐ Other _____
Where in the vehicle where you after the accident? _____
As a result of the accident, were you: ☐ Rendered unconscious How long? _____
☐ Dazed, circumstances vague
☐ Shaken up but could function
☐ Conscious, alert and aware of surroundings
☐ Other _____
Could you move all parts of your body? ☐ Yes ☐ No
If no, what body parts could you not move and why? _____
Were you able to get out of the vehicle and walk unaided? ☐ Yes ☐ No
If no, why couldn't you get out of the vehicle and walk unaided? _____

Symptoms from Accident

Did you get bleeding cuts or bruises from the accident? ☐ Yes ☐ No
If yes, what bleeding cuts or bruises did you get? _____

Describe how you felt (PLEASE BE SPECIFIC)
While at the accident scene: _____
Later that ☐ day ☐ night: _____
The next day(s): _____

What are your major complaints? (List in decreasing order of severity)
1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Doctor Use Only

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Check the symptoms you have noticed since the accident:

- ☐ Headache
- ☐ Neck Pain
- ☐ Neck Stiffness
- ☐ Mid back pain
- ☐ Mid back stiffness
- ☐ Low back pain
- ☐ Low back stiffness
- ☐ Difficulty swallowing/lump in throat
- ☐ Nervousness
- ☐ Tension
- ☐ Dizziness
- ☐ Poor memory
- ☐ Ringing/buzzing in ears/Hearing loss
- ☐ Fatigue/Drowsiness
- ☐ Irritability
- ☐ Depression/crying spells
- ☐ Fainting
- ☐ Loss of balance
- ☐ Clumsiness
- ☐ Loss of smell/taste
- ☐ Sleeping problems
- ☐ Pain behind eyes
- ☐ Eyes sensitive to light
- ☐ Blurred vision
- ☐ Numbness in fingers
- ☐ Numbness in toes
- ☐ Pins and needles in arms/legs
- ☐ Knee pain
- ☐ Difficulty swallowing
- ☐ Cold hands/feet
- ☐ Chest pain
- ☐ Breast pain
- ☐ Diarrhea/Constipation
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

Work Status

Occupation: _____ Employer: _____
Have you missed time from work? ☐ Yes ☐ No
If yes: ☐ Full time ☐ Part time Dates From _____ to _____
Unable to work since accident ☐ Yes ☐ No
Totally disabled from _____ to _____
Partially disabled from _____ to _____

First Doctor/Hospital/Clinic Seen

Did you seek medical help immediately/soon after the accident? ☐ Yes ☐ No
If yes, how did you get there? ☐ Someone else drove me ☐ Drove own vehicle ☐ Ambulance ☐ Police
Doctor 1/hospital/clinic seen: _____ Date of first visit: _____
How long were you there? _____
Were you examined? ☐ Yes ☐ No
Were x-rays taken? ☐ Yes ☐ No What body part? _____ How many? _____
Diagnosis, if known: _____
Were you given treatment? ☐ Yes ☐ No
If yes, what treatment was administered? _____
What benefits did you receive from the treatment? _____
Date of last treatment: _____

Second Doctor/Hospital/Clinic Seen

Doctor 2/hospital/clinic seen: _____ Date of first visit: _____
How long were you there? _____
Were you examined? ☐ Yes ☐ No
Were x-rays taken? ☐ Yes ☐ No What body part? _____ How many? _____
Diagnosis, if known: _____
Were you given treatment? ☐ Yes ☐ No
If yes, what treatment was administered? _____
What benefits did you receive from the treatment? _____
Date of last treatment: _____

Past history

List previous surgieries, broken bones and serious illnesses ☐ None

Incident	Year	Doctor	How do you feel now?

List previous sport injuries and military injuries ☐ None

Incident	Year	Doctor	How do you feel now?

List previous car accidents and other serious accidents ☐ None

Incident	Year	Doctor	How do you feel now?

PRIOR to the accident, have you EVER had symptoms similar to what your are experiencing now? ☐ Yes ☐ No
If yes, please explain (briefly include past falls, injuries, accidents, operations, etc.): _____

Signed: _____ Date _____