



MOTOR VEHICLE ACCIDENT HISTORY

PATIENT NAME:		DATE:
ACCIDENT INFORMATION		
DATE OF ACCIDENT:	TIME OF ACCIDENT:	WHERE WERE YOU LOCATED IN THE VEHICLE AT THE TIME OF THE ACCIDENT? <input type="checkbox"/> DRIVER <input type="checkbox"/> PASSENGER FRONT <input type="checkbox"/> PASSENGER BACK
NAME OF DRIVER:	PATIENT VEHICLE (MAKE, YEAR, MODEL):	
NAME OF OTHER DRIVER:	OTHER VEHICLE (MAKE, YEAR, MODEL):	
LOCATION OF ACCIDENT?	HEAD POSITION? <input type="checkbox"/> STRAIGHT <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT <input type="checkbox"/> OTHER _____	
HEADREST? <input type="checkbox"/> NONE <input type="checkbox"/> ADJUSTED HIGH <input type="checkbox"/> ADJUSTED LOW	SEAT BELT: <input type="checkbox"/> NONE <input type="checkbox"/> NOT WEARING <input type="checkbox"/> WEARING	
AREA OF IMPACT ON YOUR VEHICLE? <input type="checkbox"/> FRONT <input type="checkbox"/> BACK <input type="checkbox"/> LEFT SIDE <input type="checkbox"/> RIGHT SIDE	AREA OF IMPACT ON OTHER VEHICLE? <input type="checkbox"/> FRONT <input type="checkbox"/> BACK <input type="checkbox"/> LEFT SIDE <input type="checkbox"/> RIGHT SIDE <input type="checkbox"/> N/A	
WHERE WERE YOU TAKEN AFTER THE ACCIDENT? <input type="checkbox"/> HOME <input type="checkbox"/> DOCTORS OFFICE <input type="checkbox"/> HOSPITAL _____		BY AMBULANCE: <input type="checkbox"/> YES <input type="checkbox"/> NO
WHAT WAS DONE FOR YOU? <input type="checkbox"/> EXAMINATION <input type="checkbox"/> X-RAY <input type="checkbox"/> MEDICATIONS <input type="checkbox"/> OTHER:		OTHER DOCTORS SEEN:
POLICE INVESTIGATED? <input type="checkbox"/> YES <input type="checkbox"/> NO	WAS A REPORT FILED? <input type="checkbox"/> YES <input type="checkbox"/> NO	WHICH DEPARTMENT? <input type="checkbox"/> STATE PATROL <input type="checkbox"/> SHERIFF <input type="checkbox"/> CITY POLICE
YOUR VEHICLE WAS MOVING AT WHAT ESTIMATE SPEED? OTHER VEHICLE'S ESTIMATED SPEED?	AT THE TIME OF THE IMPACT WERE YOU: <input type="checkbox"/> TOTALLY SUPRISED <input type="checkbox"/> BRACED, ANTICIPATING THE IMPACT <input type="checkbox"/> STOPPED	
WAS YOUR AIRBAG DEPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO	ROAD CONDITIONS: <input type="checkbox"/> DRY <input type="checkbox"/> WET <input type="checkbox"/> ICY <input type="checkbox"/> DAMP <input type="checkbox"/> OTHER	
PHYSICAL SYMPTOMS		
INITIAL SYMPTOMS: <i>Check (✓) any/all that apply</i>		LATER SYMPTOMS: <i>Check (✓) any/all that apply</i>
<input type="checkbox"/> NONE <input type="checkbox"/> NERVOUSNESS <input type="checkbox"/> HEADACHE <input type="checkbox"/> IRRITABILITY <input type="checkbox"/> NECK PAIN <input type="checkbox"/> NUMBNESS <input type="checkbox"/> NECK STIFFNESS <input type="checkbox"/> TINGLING <input type="checkbox"/> DIZZINESS <input type="checkbox"/> HANDS/ARMS INJURY <input type="checkbox"/> MID TO UPPER BACK PAIN <input type="checkbox"/> FEET/LEGS INJURY <input type="checkbox"/> LOWER BACK PAIN <input type="checkbox"/> OTHER _____	<input type="checkbox"/> NONE <input type="checkbox"/> NERVOUSNESS <input type="checkbox"/> HEADACHE <input type="checkbox"/> IRRITABILITY <input type="checkbox"/> NECK PAIN <input type="checkbox"/> NUMBNESS <input type="checkbox"/> NECK STIFFNESS <input type="checkbox"/> TINGLING <input type="checkbox"/> DIZZINESS <input type="checkbox"/> HANDS/ARMS INJURY <input type="checkbox"/> MID TO UPPER BACK PAIN <input type="checkbox"/> FEET/LEGS INJURY <input type="checkbox"/> LOWER BACK PAIN <input type="checkbox"/> OTHER _____	
CURRENT SYMPTOMS:		

INSURANCE INFORMATION

PATIENT'S INSURANCE COMPANY NAME:

ADDRESS:

CITY/STATE/ZIP:

PHONE:

NAME OF POLICY HOLDER:

ADDRESS:

CITY/STATE/ZIP:

PHONE:

POLICY NUMBER:

CLAIM NUMBER:

ADJUSTER:

OTHER DRIVER'S INSURANCE INFORMATION

OTHER DRIVER'S INSURANCE COMPANY NAME:

ADDRESS:

CITY/STATE/ZIP:

PHONE:

NAME OF POLICY HOLDER:

ADDRESS:

CITY/STATE/ZIP:

PHONE:

POLICY NUMBER:

CLAIM NUMBER:

ADJUSTER:

OTHER ACCIDENT INFORMATION

HAVE YOU RETAINED AN ATTORNEY? YES NO

ATTORNEY'S NAME:

ATTORNEY'S ADDRESS:

ATTORNEY'S PHONE NUMBER:

DESCRIBE THE ACCIDENT:

USE THIS SPACE FOR ADDITIONAL INFORMATION:

SIGNATURE

PATIENT SIGNATURE:

DATE: