Patient Name: _____ Acct#_____
DOB: _____ Claim#_____

History of Accident

Description of Accident

Date of accident:_____ Time:_____ Driver of car:_____ Owner of car:_____
Year and model of car:_____
Where were you seated? ☐ Front Left ☐ Front Right ☐ Rear Left ☐ Rear Middle ☐ Rear Right
Where was the accident? City:_____ Street:_____ Cross Street:_____
Direction of Travel:_____
Your car: ☐ Hit another car ☐ Was hit by another car on the: ☐ Right ☐ Left ☐ Rear ☐ Front ☐ Side
Type of Accident: ☐ Head-on collision ☐ Broadside collision ☐ Rear end collision
☐ Front impact, rear-ended car in front ☐ Other

Please describe how the accident happened: (you can also draw what happened)

_____
_____
_____
_____

Was your car braking? ☐ Yes ☐ No Was your car moving at the time of accident? ☐ Yes ☐ No
If yes, how fast? _____MPH (estimate)
How fast was the other car traveling? _____MPH(estimate)
Did police come to the accident scene? ☐ Yes ☐ No Did an ambulance come to the accident scene? ☐ Yes ☐ No
Were you transported by ambulance to the hospital? ☐ Yes ☐ No If yes, what hospital? _____

During Accident

What kind of seat belt were you using? ☐ Lap belt ☐ Shoulder belt ☐ Both ☐ None
Were you aware the accident was about to happen? ☐ Yes ☐ No
Did you brace for the impact? ☐ Yes ☐ No ☐ Not sure
What was the position of the headrest compared to your head before the accident?
☐ Top of headrest even with bottom of head ☐ Top of headrest even with top of head
☐ Top of headrest even with middle of neck ☐ Unknown

Head/body position at the time of impact:
☐ Head turned left ☐ Head turned right ☐ Head looking back ☐ Head forward
☐ Body straight in sitting position ☐ Body rotated left ☐ Body rotated right
Position of arms at time of impact: (ie: on steering wheel)_____
Position of feet at time of impact: (ie: on brake)_____

Describe what happened to you upon impact: _____
_____
At the time of impact, recall what parts of your head or body hit what parts on the inside of the car:_____
_____

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After the accident, were you: ☐ Rendered unconscious ☐ Dazed, circumstances vague ☐ Shaken up, but could function
Could you move all parts of your body? ☐ Yes ☐ No
If not, what body parts could you not move, and why? _____
Were you able to get out of the car and walk unaided? ☐Yes ☐No If no, why not?_____
Did you get any bleeding, cuts, or bruises? ☐Yes ☐No If yes, please describe_____

After the Accident

Please describe how you felt immediately after the accident. Be specific._____
_____
How did you feel later that day/night?_____
The next days?_____
Did you have any physical complaints just before the accident? ☐ Yes ☐ No
If yes, please describe:_____

Activities of Daily Living

Do you notice any of your home activities that are different now than before the accident? ☐ Yes ☐ No
If yes, what activities are you now unable to do?_____
What activities are now painful to do?_____
What activities are now difficult to do?_____

Work Status History

Have you missed time from work? ☐ Yes ☐ No
If yes, what dates?_____

Treatment

Did you seek treatment at any hospital or clinic before coming here? ☐ Yes ☐ No
If yes….
First Hospital/Clinic Seen_____ Date Seen:_____
Were you examined? ☐ Yes ☐ No Were x-rays taken? ☐ Yes ☐ No
Were you given treatment? ☐ Yes ☐ No If yes, what treatment?_____
What benefits did you receive from the treatment?_____
Date of last treatment: _____

Second Hospital/Clinic Seen_____ Date Seen:_____
Were you examined? ☐ Yes ☐ No Were x-rays taken? ☐ Yes ☐ No
Were you given treatment? ☐ Yes ☐ No If yes, what treatment?_____
What benefits did you receive from the treatment?_____
Date of last treatment: _____