

Motor Vehicle Accident History

PATIENT NAME:		DATE:	
ADDRESS:		CITY:	STATE/ZIP CODE:
HOME PHONE NUMBER:		CELL PHONE NUMBER:	
SOCIAL SECURITY NUMBER:	DATE OF BIRTH:	AGE:	GENDER:
EMERGENCY CONTACT NAME:		EMERGENCY CONTACT PHONE NUMBER:	
EMPLOYER NAME:		EMPLOYER ADDRESS:	

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 <input type="checkbox"/> FRONT SEAT <input type="checkbox"/> BACK SEAT	
NUMBER OF PEOPLE IN THE CAR:	NAMES OF PEOPLE IN THE CAR WITH YOU:		
WHAT DIRECTION WAS YOUR CAR HEADED? <input type="checkbox"/> NORTH <input type="checkbox"/> SOUTH <input type="checkbox"/> EAST <input type="checkbox"/> WEST		ON WHAT STREET WERE YOU HEADED?	
WHAT DIRECTION WAS THE OTHER CAR HEADED? <input type="checkbox"/> NORTH <input type="checkbox"/> SOUTH <input type="checkbox"/> EAST <input type="checkbox"/> WEST		WERE YOU STRUCK FROM: <input type="checkbox"/> BEHIND <input type="checkbox"/> FRONT <input type="checkbox"/> LEFT SIDE <input type="checkbox"/> RIGHT SIDE	
WERE YOU KNOCKED UNCONSCIOUS? <input type="checkbox"/> YES <input type="checkbox"/> NO		DID YOU HIT YOUR HEAD? <input type="checkbox"/> YES <input type="checkbox"/> NO	
WHERE WERE YOU TAKEN AFTER THE ACCIDENT?			BY AMBULANCE: <input type="checkbox"/> YES <input type="checkbox"/> NO
WERE THE POLICE ON THE SCENE? <input type="checkbox"/> YES <input type="checkbox"/> NO	WAS A REPORT FILED? <input type="checkbox"/> YES <input type="checkbox"/> NO	DO YOU HAVE A COPY? <input type="checkbox"/> YES <input type="checkbox"/> NO	
HAVE YOU BEEN TREATED BY ANY OTHER DOCTORS FOR THIS ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		SINCE THE INJURY, ARE YOUR SYMPTOMS: <input type="checkbox"/> IMPROVING <input type="checkbox"/> GETTING WORSE <input type="checkbox"/> GETTING BETTER	
HAVE YOU LOST TIME FROM WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		DATE YOU LEFT WORK:	DATE YOU RETURNED TO WORK:
HAVE YOU BEEN INVOLVED IN AN ACCIDENT IN THE PAST? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, PLEASE DESCRIBE:	
DO YOU HAVE ANY PREVIOUS ILLNESSES WHICH RELATE TO THIS CASE? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, PLEASE DESCRIBE:	
DO YOU HAVE ANY ACTIVITY RESTRICTIONS AS A RESULT OF THIS INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, PLEASE DESCRIBE:	

INSURANCE INFORMATION

AUTO INSURANCE COMPANY NAME:	
ADJUSTER NAME:	ADJUSTER PHONE NUMBER:
POLICY NUMBER:	CLAIM NUMBER:

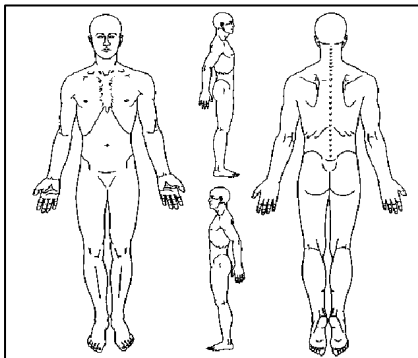
ACCIDENT INFORMATION

DESCRIBE THE ACCIDENT IN YOUR OWN WORDS:

INSTRUCTIONS: CHECK (✓) ANY/ALL SYMPTOMS NOTED AFTER THE ACCIDENT.

- | | | |
|--|---|---|
| <input type="checkbox"/> HEADACHE | <input type="checkbox"/> DIZZINESS | <input type="checkbox"/> LIGHT BOTHERS EYES |
| <input type="checkbox"/> NECK PAIN | <input type="checkbox"/> HEAD SEEMS HEAVY | <input type="checkbox"/> LOSS OF MEMORY |
| <input type="checkbox"/> NECK STIFFNESS | <input type="checkbox"/> PINS & NEEDLES IN ARMS | <input type="checkbox"/> EARS RING |
| <input type="checkbox"/> SLEEPING PROBLEMS | <input type="checkbox"/> PINS & NEEDLES IN LEGS | <input type="checkbox"/> FACE FLUSHED |
| <input type="checkbox"/> BACK PAIN | <input type="checkbox"/> NUMBNESS IN FINGERS | <input type="checkbox"/> BUZZING IN EARS |
| <input type="checkbox"/> NERVOUSNESS | <input type="checkbox"/> NUMBNESS IN TOES | <input type="checkbox"/> LOSS OF BALANCE |
| <input type="checkbox"/> TENSION | <input type="checkbox"/> SHORTNESS OF BREATH | <input type="checkbox"/> FAINTING |
| <input type="checkbox"/> IRRITABILITY | <input type="checkbox"/> FATIGUE | <input type="checkbox"/> LOSS OF SMELL |
| <input type="checkbox"/> CHEST PAIN | <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> LOSS OF TASTE |
| <input type="checkbox"/> DIARRHEA | <input type="checkbox"/> FEET FEEL COLD | <input type="checkbox"/> UPSET STOMACH |
| <input type="checkbox"/> CONSTIPATION | <input type="checkbox"/> HANDS FEEL COLD | <input type="checkbox"/> OTHER: _____ |
| <input type="checkbox"/> FEVER | <input type="checkbox"/> COLD SWEATS | <input type="checkbox"/> OTHER: _____ |

INSTRUCTIONS: Please mark the area and type of pain on the drawings using the codes listed below:
N=Numbness P=Pain A=Ache T=Tingling S=Stiffness/Soreness



COMMENTS:

PLEASE PROVIDE ANY OTHER PERTINENT INFORMATION YOU THINK WE SHOULD KNOW:

DOCTOR ONLY

DOCTOR COMMENTS:

SIGNATURE

PATIENT SIGNATURE:

DATE: