Motor Vehicle Accident History

GENERAL INFORMATION

PATIENT NAME:

ADDRESS: **CITY:** **STATE/ZIP:**

HOME PHONE: **CELL PHONE:**

DOB: **GENDER:** **SSN:**

INSURANCE CO.: **POLICYHOLDER:** ☐ **AT FAULT PARTY** ☐ **WORK COMP**

ADJUSTER NAME: **PHONE:** **FAX:**

POLICY NUMBER: **CLAIM NUMBER:**

HAVE YOU RETAINED AN ATTORNEY? ☐ YES ☐ NO **NAME:** **PHONE:**

ACCIDENT INFORMATION

DATE OF ACCIDENT: **TIME:** **STREET OF ACCIDENT:**

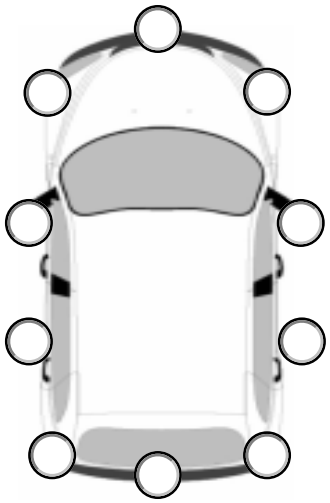
CROSS STREET (INTERSECTION): **CITY:**

DIRECTION YOUR VEHICLE WAS HEADED: ☐ NORTH ☐ EAST ☐ SOUTH ☐ WEST **OTHER VEHICLE:** ☐ NORTH ☐ EAST ☐ SOUTH ☐ WEST

DID POLICE COME TO SCENE? ☐ YES ☐ NO **ACCIDENT REPORT FILED?** ☐ YES ☐ NO **DO YOU HAVE A COPY OF REPORT?** ☐ YES ☐ NO

Initial Impact:

Please mark where your vehicle was struck. Place an **X** where you were seated:



Other Type Vehicle Driving if Not Automobile:

☐ MOTORCYCLE/SCOOTER
☐ ATV
☐ GOLF CART
☐ OTHER_____

WHERE WERE YOU LOCATED IN VEHICLE AT TIME OF ACCIDENT? (Check as many as apply)

☐ PEDESTRIAN ☐ DRIVER ☐ PASSENGER ☐ FRONT SEAT ☐ BACK SEAT

WEARING A SEATBELT? ☐ YES ☐ NO **IF YES, WHAT TYPE?** ☐ LAP BELT ☐ SHOULDER BELT

WERE YOU AWARE OF THE APPROACHING COLLISION OR DID THE IMPACT CATCH YOU BY SURPRISE?

☐ AWARE ☐ SURPRISED

WHICH WAY WERE YOU LOOKING AT IMPACT? ☐ FORWARD ☐ RIGHT ☐ LEFT ☐ UP ☐ DOWN

WAS YOUR VEHICLE MOVING OR STOPPED? ☐ MOVING ☐ STOPPED

If moving, how fast were you going approximately?_____

Just before impact, the vehicle was: ☐ SLOWING DOWN ☐ SPEEDING UP ☐ CONSTANT SPEED

DID YOU LOSE CONSCIOUSNESS (BLACK OUT)? ☐ YES ☐ NO **IF YES, HOW LONG?**

DID YOU HIT YOUR HEAD? ☐ YES ☐ NO **ON WHAT OBJECT?**

WHERE DID OTHER BODY PARTS HIT?

WERE YOU TAKEN TO HOSPITAL? ☐ YES ☐ NO **NAME OF HOSPITAL:**

HOW DID YOU GET THERE? ☐ AMBULANCE ☐ DROVE SELF ☐ SOMEONE ELSE ☐ POLICE ☐ OTHER

TREATMENT RECEIVED:

☐ XRAYS: ☐ HEAD ☐ NECK ☐ UPPER BACK ☐ MID BACK ☐ LOW BACK ☐ OTHER _____

☐ CT SCAN:

☐ MRI

☐ MEDICATIONS (list names):_____

☐ OTHER TREATMENT:_____

TREATED BY ANY OTHER DOCTOR FOR THIS ACCIDENT? ☐ YES ☐ NO **IF YES, WHAT IS THEIR SPECIALITY?**

TREATMENT RECEIVED: **HOW LONG UNDER CARE?**

DESCRIBE ACCIDENT IN YOUR OWN WORDS:

POST AUTO ACCIDENT

DID YOU FEEL PAIN IMMEDIATELY FOLLOWING ACCIDENT? ☐ YES ☐ NO

If no, how long before pain started: ☐ 30 min—1 hr ☐ 1—4 hours ☐ 4—12 hours ☐ 12—24 hours ☐ _____ Days

SINCE INJURY, ARE YOUR SYMPTOMS: ☐ IMPROVING ☐ WORSENING

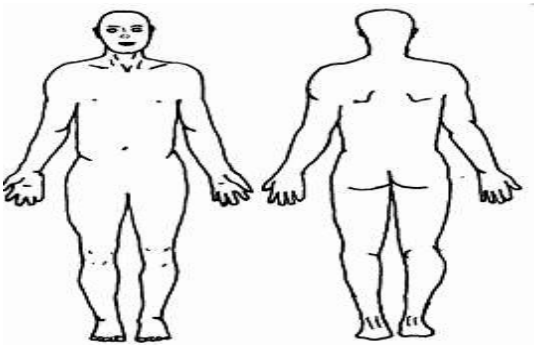
INSTRUCTIONS: ***CHECK ANY/ALL SYMPTOMS NOTED AFTER THE ACCIDENT.***

☐ HOSPITALIZATION	☐ FAINTING	☐ RINGING OR BUZZING IN EARS	☐ SHORTNESS OF BREATH
☐ HEADACHES	☐ COLD SWEATS	☐ BACK PAIN	☐ UPSET STOMACH
☐ HEAD SEEMS HEAVY	☐ SLEEP PROBLEMS	☐ MUSCLE SPASMS OR TENSION	☐ DIARRHEA OR CONSTIPATION
☐ JAW PAIN	☐ FATIGUE	☐ RADIATING PAIN	☐ NERVOUSNESS/ANXIETY
☐ NECK PAIN AND/OR STIFFNESS	☐ CONTUSIONS (BRUISES)	☐ RESTRICTED MOVEMENT	☐ DEPRESSION
☐ FEVER	☐ SENSITIVITY TO TOUCH	☐ PINS & NEEDLES IN ARMS OR LEGS	☐ IRRITABILITY
☐ DIZZINESS	☐ VISUAL DISTURBANCES	☐ NUMBNESS IN FINGERS OR TOES	☐ FACE FLUSHED
☐ LOSS OF BALANCE	☐ LOSS OF SMELL	☐ HANDS OR FEET FEEL COLD	☐ OTHER: _____
☐ LOSS OF MEMORY	☐ LOSS OF TASTE	☐ CHEST PAIN	_____

INSTRUCTIONS: *Please mark the area and type of pain using:*

N = Numbness **P =** Pain **A =** Ache

T = Tingling **S =** Stiffness/Soreness



DESCRIBE THE ACCIDENT'S EFFECT ON YOUR ACTIVITIES OF DAILY LIVING (ADL'S)

1 = No effect **2 =** Painful (I can do it) **3 =** Painful (I'm limited) **4 =** unable to perform

Carrying for Immediate Family _____ Self Care (Grooming, Dressing) _____

Carrying Groceries _____ Sexual Activities _____

Change Position (Sit to Stand or Vice Versa)_____ Sleeping _____

Climbing Stairs _____ Static Sitting (Still)_____

Driving _____ Static Standing (Still)_____

Extended Computer Use _____ Yard Work _____

Household Chores _____ Job Duties _____

Lifting Children _____ Sports/Hobbies _____

Walking _____ Social Events_____

Other activities (list and rate):_____

HAVE YOU LOST TIME FROM WORK? ☐ YES ☐ NO **DATE LEFT:** **DATE RETURNED:**

ANY PAST MOTOR VEHICLE ACCIDENTS? ☐ YES ☐ NO **EXPLAIN:**

OTHER PERTINENT INFORMATION YOU THINK WE SHOULD KNOW:

HAVING ATTORNEY/INSURANCE IS NOT A GUARANTEE YOUR FEES WILL BE PAID IN FULL. THE PATIENT IS ULTIMATELY RESPONBISLE FOR THE REMAINING BALANCE. PLEASE REMAIN IN CONSTANT CONTACT WITH ATTORNEY/INSURANCE CONCERNING YOUR CASE.

PATIENT SIGNATURE: Sign in office

DATE: Date in office