Automobile Accident History Form

Today's Date: _____ Patient Name:_____

Date of Injury: _____ Marital Status: ☐ M ☐ S ☐ W ☐D

Date of Birth _____
Habits: Smoking: _____ Pk/day. How many years? _____
Alcohol: _____ drinks/day _____ drinks/week

Employment at date of accident _____

Current Employment _____ Unemployed due to crash? _____
Type of Work: ☐Office/Clerical ☐ Light Labor ☐ Moderate Labor ☐Heavy Labor

Were you put on a work restriction? ☐ No ☐Yes _____ Pounds _____ Dates

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Was the crash on-the-job? ☐ No ☐ Yes
You were: ☐ Driver ☐ Front seat passenger ☐ Rear Seat Passenger ☐Motorcycle operator
☐ Motorcycle passenger ☐Other: Explain _____

Vehicle driven by: _____ Year/ Make/ Model _____

Your estimated speed at impact _____ MPH ☐ Stopped ☐ Slowing ☐ Accelerating

Other Vehicle driver: _____ Year/ Make/ Model_____
Time of day: _____AM/ PM Condition ☐Daylight ☐Dawn ☐ Dusk ☐ Dark
Road Conditions: ☐ Dry ☐Damp ☐Wet ☐Snow ☐ Ice ☐ Other explain _____

Head restraints: ☐ none ☐ fixed ☐ adjustable If adjustable was it ☐up ☐ down

If adjustable head rest, was the position altered by the crash? ☐No ☐Yes
Was the seat back altered by the crash? ☐ No ☐ Yes Was it broken? ☐No ☐ Yes
Lap belt: ☐Wearing ☐ Not wearing ☐ None present
Shoulder belt: ☐Wearing ☐ Not wearing ☐ None present
Did an air bag deploy on your vehicle? ☐No ☐Yes If yes, were you struck by it? ☐No ☐ Yes
Body position ☐ Seated, faced forward ☐ Leaning forward ☐turned sideways ☐ Right ☐ Left
Head position ☐ Forward ☐Left ☐ Right ☐ Up ☐Down
Hands braced on steering wheel or other part of the vehicle? ☐ R ☐ L ☐ Both
Were your brakes applied? ☐ No ☐Yes

Crash Description: _____

_____

_____

_____

_____

Crash Diagram:

Were you aware the crash was about to happen? ☐ No ☐Yes

During the crash:
Did you strike any parts of the vehicle? ☐No ☐ Yes Which part(s)_____

Did your vehicle strike any objects after the initial impact? ☐ No ☐Yes _____
Wearing hat or glasses? ☐No ☐Yes If yes, were they still on after the crash? ☐No ☐Yes
Did you lose consciousness? ☐ No ☐ Yes How long? _____

Estimated property damage to your vehicle. ☐None ☐Minimal ☐Moderate ☐Major _____$

Estimated damage to the other vehicle ☐None ☐ Minimal ☐ Moderate ☐ Major _____$
Did the police come to the scene? ☐ No ☐Yes Was a police report made? ☐ No ☐Yes
After crash symptoms: ☐ Headache ☐ Dizziness ☐ Nausea ☐ Confusion ☐Disorientation
☐Numbness/ tingling (areas)_____
Did you have: ☐ Neck pain ☐ Back pain ☐Extremity pain Which one(s)_____
When did symptoms first appear? ☐ Immediately ☐_____ # Hours After ☐ _____ # Days After
Where did you go after the crash? ☐ Home ☐ Work ☐ Hospital ☐ Ambulance
Emergency department: Radiographs taken? ☐ No ☐Yes Body part(s) imaged._____

Lab work ☐ No ☐ Yes Ice: ☐ No ☐Yes Neck brace: ☐ No ☐Yes Cast: ☐ No ☐Yes

Test findings: _____

Medication(s) _____

Follow up instructions: _____

Other provider's seen/ specialty/ treatment type/ frequency/ duration/ disability? _____

_____

_____

_____

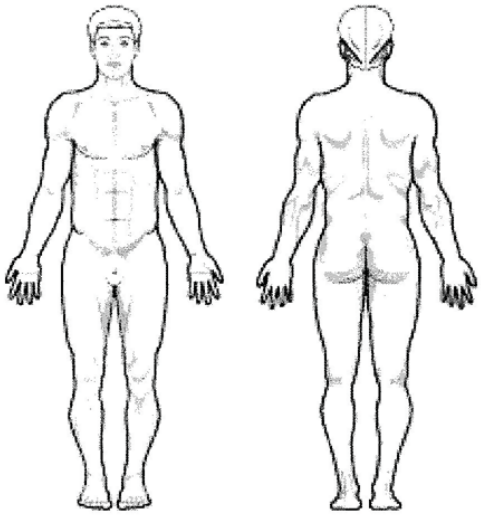
_____

_____

Did treatment help? ☐No ☐Yes Are you still under their care? ☐ No ☐Yes

Your 4 Major Symptoms:
List and describe the problems you are having and draw them on the chart.

1._____
2. _____
3._____
4. _____



Grade your problem from:

1 (gone) to 10 (very severe)

Problem #	Grade
1	1 2 3 4 5 6 7 8 9 10
2	1 2 3 4 5 6 7 8 9 10
3	1 2 3 4 5 6 7 8 9 10
4	1 2 3 4 5 6 7 8 9 10

Doctor's Comments:

_____

_____

List other symptoms you have experienced since the accident: _____

_____

_____