AUTOMOBILE ACCIDENT HISTORY FORM

Your Name:____ Today's Date: _______________

Your auto insurance information:
Insurance company:____ Phone: ____________________________
Agent/Adjusters Name:____ Claim #: ___________________________
Attorney's Name:____ Phone: ____________________________

The At Fault's Auto insurance information:
Insurance Company:____ Phone: ____________________________
Agent/Adjuster's Name:____ Claim #: ___________________________
Date of Accident:_________________Time of Accident:______________am/pm
City & Street of Accident: ____
Road Conditions at the time of the accident: ☐ WET ☐ DRY ☐ ICY ☐ OTHER__________________________
Did the police come to the accident scene? ☐ YES ☐ NO Is there a report? ☐ YES ☐ NO
Did you go to a hospital? ☐ YES ☐ NO
If yes, what is the name and city of the hospital?____
How did you get to the hospital? ____
What parts of your body were x-rayed at the hospital? ____
What did the hospital do for your injuries? ____
How long did you stay at the hospital? ____
What bleeding cuts did you sustain during this accident? ____
What bruises did you sustain during this accident? ____
Where were you seated in the vehicle? ____
Were you aware of the approaching collision prior to impact, or did impact catch you by surprise?
☐ AWARE ☐ SURPRISE
Did you lose consciousness (black out) upon impact? ☐ YES ☐ NO
How long? ____
Did you experience a flash of light or explosion in your head? ____

Did you become ☐ CONFUSED ☐ DISORIENTED ☐ LIGHT HEADED DIZZY
☐ NAUSEATED ☐ BLURRED VISION ☐ RING/BUZZ IN EARS
If you still have some of those symptoms, which ones? ____
Are you currently suffering from any of the following (please select):
☐ RESTLESSNESS ☐ IRRITABLE
☐ DIFFICULT CONCENTRATING ☐ DIFFICULT WITH MEMORY
☐ SLEEPLESSNESS ☐ FORGETFULNESS
☐ REDUCED TOLERANCE TO HEAT ☐ REDUCED TOLERANCE TO ALCOHOL
How far is the top of the headrest or seatback from the top of your head (approximately)?
________________________Inches ABOVE or BELOW
Were you wearing a seatbelt? ☐ YES ☐ NO
If yes, was it a lap seatbelt_____________________________or shoulder-lap seatbelt_________________________________

List the year, make and model of the vehicle you were in:

Year______________________________ make_____________________________ model ____________________________

Was your car stopped at the time of impact? ☐ YES ☐ NO

If yes, was the driver's foot also on the brake? ☐ YES ☐ NO

If no, then estimate the speed of the vehicle you were in: _________________________________mph

If your vehicle was moving at the time of impact, was it: (please select)

☐ Slowing down ☐ Gaining speed ☐ Traveling at a steady rate of speed

On what part of the automobile did your following body parts hit?

Head hit____ chest hit _____________________________________

Right/left shoulder hit_____________________________________ right/left arm hit _______________________________

Right/left hip hit____ right/left leg hit ________________________________

Did you receive any injury or bruise from the seat belt? ☐ YES ☐ NO

If YES, then describe: ____

What is the estimated cost damage to the vehicle you were in? $_________________________

Which of the following car parts broke during the accident? (Please select)

☐ Windshield ☐ front seat back

☐ Right/left side window ☐ other ____

☐ Steering wheel ☐ other ____

Was the trunk of your body pointed straightforward at the time of the collision? ☐ YES ☐ NO

If no, how was it turned? ____

Was your head pointed straightforward? ☐ YES ☐ NO

If no, what direction was it turned and by how much? ____

What is the year, make and model of the other vehicle?

Year______________________________ make_____________________________ model ____________________________

Was the other vehicle moving at the time of the collision? ☐ YES ☐ NO

If yes, what was its approximate speed?_____________________Mph

If the other vehicle was moving at the time of the collision, was it (please select):

☐ Slowing down ☐ Gaining speed ☐ Traveling at a steady speed

Please describe, to the best of your knowledge, what happened during this accident:

____

____

____

____

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Activities of Daily Living

Patient Name: ____

Check each of the activities which you have difficulty performing and or can perform only with pain. (There is no particular priority in the order presented).

HOUSEWORK

☐ Doing Laundry
☐ Making Beds
☐ Vacuuming
☐ Washing Dishes
☐ Ironing ☐ Other________________________________
☐ Carrying groceries
☐ Caring for pets
☐ Cooking
☐ Other__

PERSONAL GROOMING

☐ Combing Hair
☐ Shaving
☐ In/out bathtub
☐ Brushing teeth

TRAVEL

☐ Driving
☐ Riding

YARDWORK

☐ Mowing lawn
☐ Shoveling snow
☐ Raking leaves
☐ Gardening
☐ Other____________________________

Minutes per Day

Type of vehicle

Auto ________________________________
Train ________________________________
Bus ________________________________
Truck ________________________________
Airplane ________________________________

GENERAL

☐ Walking
☐ Standing
☐ Running
☐ Sitting
☐ Lifting children
☐ Bending
☐ Climbing stairs
☐ Reading
☐ Lying in bed
☐ Chewing
☐ Getting in/out of auto
☐ Playing piano
☐ Using computer
☐ Kneeling
☐ Sexual intercourse
☐ Exercising
☐ Sleeping
☐ Using telephone
☐ Sitting in recliner
☐ Swimming

☐ Sports: List: ____

OTHER: Please list any other difficulties you are experiencing with activities you have engaged in since your condition arose:

____

____

Signature: ____________________________________ Date: __________________