

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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215 S. Garber Drive
Tipp City, OH 45371
(937) 667-7700

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__

YARDWORK

- Mowing lawn
- Shoveling snow
- Raking leaves
- Gardening
- Other _____

GENERAL

- Walking
- Standing
- Running
- Sitting
- Lifting children
- Bending
- Climbing stairs
- Reading
- Lying in bed
- Chewing

PERSONAL GROOMING

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

TRAVEL

- Driving
- Riding

Minutes per Day _____

Type of vehicle _____

Auto _____

Train _____

Bus _____

Truck _____

Airplane _____

- 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: _____