 **Automobile Accident**

**History Form**

Name:Patient Full Name. Date: Click here to enter the date.

Date of accident: Accident date. Time of accident: Accident Time.Choose an item.

City of accident: City. Street of accident: Street or intercetion.

Did police come to the scene? **Yes**  **No**

Is there a police report?  **Yes**  **No**

Did you go to the hospital?  **Yes**  **No** Did you ride in an ambulance? **Yes**  **No**

If yes…what is the name of hospital: Hospital.

Any x-rays, scans, MRI’s or other tests? Tests.

What treatment did you receive? Treatment.

How long did you stay? Length of stay.

What bruises, cuts, scrapes did you receive? Click here to enter text.

Were you aware of the approaching collision before impact?  **Yes**  **No**

Did you lose consciousness (black out) after impact?  **Yes**  **No**

Did you experience a flash of light or ‘explosion’ in your head?  **Yes**  **No**

Did you suffer any of the following symptoms from the accident?

**Confused**  **Disoriented**  **Light headed**  **Dizzy**  **Blurred vision**

**Ringing/buzzing ears**  **Nauseated**  **Changes in bowel or bladder**

Do you still have any of these symptoms?**Yes** **No**

Are you currently suffering from any of the following?

**Restlessness**  **Irritable**  **Sleeplessness**  **Forgetfulness**

**Difficulty concentrating**  **Difficulty with memory**

**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) Height. inches  **above** or **below**.

Were you wearing a seatbelt:  **Yes**  **No**

If yes, was it a lap seatbelt or a shoulder-lap seatbelt?

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

Year: Year. Make: Make. Model: 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: Estimate. mph.

If your vehicle was moving at the time of impact, was it:

Slowing down?  **Yes**  **No**

Gaining speed?  **Yes**  **No**

Traveling at a steady rate of speed?  **Yes**  **No**

Did any part of you body hit a part of the vehicle?  **Yes**  **No**

If Yes, on what part of the automobile did your following body parts hit?

Head hit Window, Steering wheel, etc. Chest hit Window, Steering wheel, etc.

Right/left shoulder Window, Steering wheel, etc. Right/left arm Window, Steering wheel, etc.

Right/left hip Window, Steering wheel, etc. Right/left leg Window, Steering wheel, etc.

Right/left knee Window, Steering wheel, etc. Other Window, Steering wheel, etc.

Did you receive any injury or bruise from the seat belt?  **Yes**  **No**

If yes, please describe: Location/Color/Duration.

Was your body pointed straight forward at the time of impact?  **Yes**  **No**

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

What is the year, make and model of the **other** car?

Year: Year. Make: Make. Model: Model.

If the other vehicle was moving at the time of the collision, was it:

Slowing down  Gaining speed  Traveling at a steady speed

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

The events of the accident.

Driver of other Vehicle’s Name: Driver’s Name.

Insurance Co: Company. Policy #: Policy Number.

Local Agent: Agent. Phone #: Phone Number.

Did they receive a ticket? **Yes No**

Did you receive a ticket? **Yes No**