Date: ______________
Patient # ____________

Automobile Accident History

Last ______________________ First ____________________ Middle Initial ______ Birth Date ____________ Age _____
Address ______________________________ City ____________________ ST_______ Zip _______________
Phone (H) ______________________ (W) __________________________ (C) ______________________
Email ____ May we send you our online newsletter? ☐yes ☐no
Occupation ______________________________ Employer ______________________________________
Spouse's Name __________________ Business/Employer __________________ Spouse Phone: ______________
Who is your primary care physician? __________________________ Address: ___________________________
Phone: ____________________ Date of last physical/exam? ______________ With Whom? ____________________

Date of Accident: ________________ Time of Accident: __________ am / pm ☐Daylight ☐Dawn ☐Dusk ☐Dark
Road conditions at the time of the accident: ☐Wet ☐Dry ☐Snow ☐Ice ☐Other ______________________________
Was the accident on the job? ☐Yes ☐No Where you in a company vehicle? ☐Yes ☐No
Where were you seated in the vehicle? ☐Driver ☐Passenger ☐Rear-seat ☐Other ___________________________
Were you aware of the approaching collision prior to impact, or did it catch you by surprise? ☐Aware ☐Surprise
Did you lose consciousness upon impact? ☐Yes ☐No Did you experience a flash of light or explosion in your head? ☐Yes ☐No
Did the police come to the accident scene? ☐Yes ☐No Is there a police report? ☐Yes ☐No

Did you go to the hospital? ☐Yes ☐No When? ☐Immediately ☐___hours later ☐___days later Which hospital? ______________
How did you get to the hospital? ____________________________ How long did you stay in the hospital? ______________
What did the hospital do for your injuries? (collars, splints, x-rays, medication etc.)______________________________
What areas were x-rayed? ____________________________What was their diagnosis? ____________________________
What did they recommend for follow-up care? ____
Was any other doctor consulted after your accident? ☐Yes ☐No If yes, please complete information below.

Dr. ____________________________ Specialty?________________________ Date first seen:________________
Type of treatment:________________________ Treatment frequency:______________ How long did you treat?________
Dr. ____________________________ Specialty?________________________ Date first seen:________________
Type of treatment:________________________ Treatment frequency:______________ How long did you treat?________

Were you wearing a seatbelt? ☐Yes ☐No If yes, did you receive any injury or bruise from the seat belt? ☐Yes ☐No
Did your head hit the head rest during the accident? ☐Yes ☐No If adjustable, was the position of the head rest altered? ☐Yes ☐No
Was the seat adjustment altered by the accident? ☐Yes ☐No Was the seat broken by the accident? ☐Yes ☐No
Did the air-bag deploy? ☐Yes ☐No If yes, did it strike you? ☐Yes ☐No If yes, where? ___________________________
Which way was your head pointing at the point of impact? ☐Straight ☐Right ☐Left Body? ☐Straight ☐Right ☐Left
Where were your hands? ☐One on the wheel ☐Both on the wheel ☐Not Applicable
Were you wearing a hat or glasses at the time of impact? ☐Yes ☐No If so, were they still on after the accident? ☐Yes ☐No