Auto Accident History Form

Patient Name:_____ Date:_____

Date of Accident:_____ Time of Accident: _____

Where did the accident take place? *(Street/Intersection, City State)* _____

At what speed were you traveling at the time of impact? _____mph

At what speed was the other car traveling at the time of impact? _____mph

Description of Accident: _____

_____

_____

_____

_____

_____

_____

Please Circle the appropriate response(s)

Were you a **passenger** / **driver** ? Did you hit your head? **Y** / **N**

Seated in **Left** / **Right** **Front** / **Back** ? Did the airbags deploy? **Y** / **N**

Were you wearing a safety harness? **Y** / **N** Did you brace for the impact? **Y** / **N**

Vehicle Information

Driver	Make	Model	Year
1)			
2)			
3)			
4)			

Please describe any damages to the vehicles: _____

_____

_____

_____

Please continue on reverse

What direction were you facing at the time of impact? **Left** **Right** **Straight**

Did any part of your body hit the inside of the vehicle? **Y** / **N** If yes, describe: _____

_____

_____

Did you go to the emergency room? **Y** / **N**

Were you hospitalized? **Y** / **N**

Have X-rays, MRI's or other tests been taken? **Y** / **N**

Have you missed time at work? **Y** / **N**

Have you taken any pain medication? **Y** / **N** If yes, describe: _____

Has pain affected your daily activities? **Y** / **N** If yes, explain: _____

_____

_____

Have you had any other symptoms since the accident? (ie: nausea, dizziness) **Y** / **N**

If yes, explain: _____

_____

Have you missed time at work? **Y** / **N** If yes, how much? _____

We will need copies of the following information:

- ❑ Police Report
- ❑ Your Auto Insurance Information
- ❑ The Other Driver's Auto Insurance Information
- ❑ Any pertinent medical records, X-rays or MRI's
- ❑ Ambulance Report
- ❑ Hospital Report