Motor Vehicle Accident History

PATIENT NAME:			DATE:
ADDRESS:		CITY:	STATE/ZIP CODE:
HOME PHONE NUMBER:		CELL PHONE NUMBER:	
SOCIAL SECURITY NUMBER:	DATE OF BIRTH:	AGE:	GENDER:
EMERGENCY CONTACT NAME:		EMERGENCY CONTACT PHONE NUMBER:	
EMPLOYER NAME:		EMPLOYER ADDRESS:	

ACCIDENT INFORMATION

DATE OF ACCIDENT:	TIME OF ACCIDENT:	WHERE WERE YOU LOCATED IN THE VEHICLE AT THE TIME OF THE ACCIDENT? ❑ DRIVER ❑ PASSENGER ❑ FRONT SEAT ❑ BACK SEAT
NUMBER OF PEOPLE IN THE CAR:	NAMES OF PEOPLE IN THE CAR WITH YOU:	
WHAT DIRECTION WAS YOUR CAR HEADED? ❑ NORTH ❑ SOUTH ❑ EAST ❑ WEST		ON WHAT STEET WERE YOU HEADED?
WHAT DIRECTION WAS THE OTHER CAR HEADED? ❑ NORTH ❑ SOUTH ❑ EAST ❑ WEST		WERE YOU STRUCK FROM: ❑ BEHIND ❑ FRONT ❑ LEFT SIDE ❑ RIGHT SIDE
WERE YOU KNOCKED UNCONSCIOUS? ❑ YES ❑ NO		DID YOU HIT YOUR HEAD? ❑ YES ❑ NO
WHERE WERE YOU TAKEN AFTER THE ACCIDENT?		BY AMBULANCE: ❑ YES ❑ NO
WERE THE POLICE ON THE SCENE? ❑ YES ❑ NO	WAS A REPORT FILED? ❑ YES ❑ NO	DO YOU HAVE A COPY? ❑ YES ❑ NO
HAVE YOU BEEN TREATED BY ANY OTHER DOCTORS FOR THIS ACCIDENT? ❑ YES ❑ NO		SINCE THE INJURY, ARE YOUR SYMPTOMS: ❑ IMPROVING ❑ GETTING WORSE ❑ SAME
HAVE YOU LOST TIME FROM WORK? ❑ YES ❑ NO		DATE YOU LEFT WORK: / DATE YOU RETURNED TO WORK:
HAVE YOU BEEN INVOLVED IN AN ACCIDENT IN THE PAST? ❑ YES ❑ NO		IF YES, PLEASE DESCRIBE:
DO YOU HAVE ANY PREVIOUS ILLNESSES WHICH RELATE TO THIS CASE? ❑ YES ❑ NO		IF YES, PLEASE DESCRIBE:
DO YOU HAVE ANY ACTIVITY RESTRICTIONS AS A RESULT OF THIS INJURY? ❑ YES ❑ NO		IF YES, PLEASE DESCRIBE:

INSURANCE INFORMATION

AUTO INSURANCE COMPANY NAME:	
ADJUSTER NAME:	ADJUSTER PHONE NUMBER:
POLICY NUMBER:	CLAIM NUMBER:

ACCIDENT INFORMATION

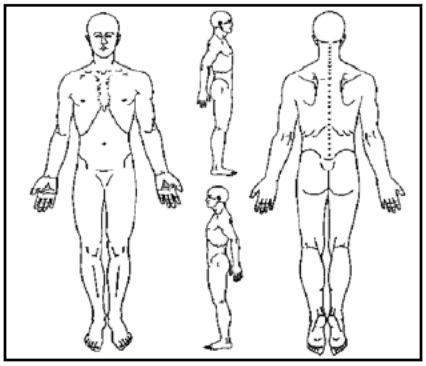
DESCRIBE THE ACCIDENT IN YOUR OWN WORDS:

INSTRUCTIONS: *CHECK (✓) ANY/ALL SYMPTOMS NOTED AFTER THE ACCIDENT.*

- ❑ HEADACHE
- ❑ NECK PAIN
- ❑ NECK STIFFNESS
- ❑ SLEEPING PROBLEMS
- ❑ BACK PAIN
- ❑ NERVOUSNESS
- ❑ TENSION
- ❑ IRRITABILITY
- ❑ CHEST PAIN
- ❑ DIARRHEA
- ❑ CONSTIPATION
- ❑ FEVER
- ❑ DIZZINESS
- ❑ HEAD SEEMS HEAVY
- ❑ PINS & NEEDLES IN ARMS
- ❑ PINS & NEEDLES IN LEGS
- ❑ NUMBNESS IN FINGERS
- ❑ NUMBNESS IN TOES
- ❑ SHORTNESS OF BREATH
- ❑ FATIGUE
- ❑ DEPRESSION
- ❑ FEET FEEL COLD
- ❑ HANDS FEEL COLD
- ❑ COLD SWEATS
- ❑ LIGHT BOTHERS EYES
- ❑ LOSS OF MEMORY
- ❑ EARS RING
- ❑ FACE FLUSHED
- ❑ BUZZING IN EARS
- ❑ LOSS OF BALANCE
- ❑ FAINTING
- ❑ LOSS OF SMELL
- ❑ LOSS OF TASTE
- ❑ UPSET STOMACH
- ❑ OTHER: _____
- ❑ OTHER: _____

INTRUCTIONS: *Please mark the area and type of pain on the drawings using the codes listed below:*

N=Numbness P=Pain A=Ache T=Tingling S=Stiffness/Soreness



COMMENTS:

PLEASE PROVIDE ANY OTHER PERTINENT INFORMATION YOU THINK WE SHOULD KNOW:

DOCTOR ONLY

DOCTOR COMMENTS:

SIGNATURE

PATIENT SIGNATURE:	DATE: