ACCIDENT HISTORY

Name: _____ Age: _____ Date of Birth: _____ ☐ Male ☐ Female

Date of Accident: _____ Hour: _____ ☐ AM ☐ PM Location: _____

ACCIDENT HISTORY ☐ Auto Injury ☐ Work Injury ☐ Other Injury: _____

Please describe the accident in detail: _____

Did anyone witness the accident? ☐ yes ☐ no Did you report the injury to your employer? ☐ yes ☐ no

Were you: ☐ Driver ☐ Passenger ☐ Front seat ☐ Back seat ☐ Pedestrian

Were you struck from: ☐ Behind ☐ Front ☐ Left side ☐ Right side ☐ Vehicle stopped

What direction were you headed: _____ Name of street you were on: _____

Did your vehicle strike another vehicle? ☐ yes ☐ no Did their vehicle strike your vehicle? ☐ yes ☐ no

Did the driver of your vehicle get a ticket? ☐ yes ☐ no Did the driver of the other vehicle? ☐ yes ☐ no

Were police notified? ☐ yes ☐ no Did you require hospitalization for these injuries? ☐ yes ☐ no

Have you been treated by a family doctor or E.R. doctor since the accident? ☐ yes ☐ no Please give the name and address of the treating doctor: _____

What type of treatment did you receive? _____

GENERAL SYMPTOMS Are your symptoms: ☐ Better ☐ Same ☐ Getting worse

Please describe your symptoms in detail: _____

Do you notice any activity restrictions as a result of this injury? ☐ yes ☐ no If yes please describe in detail:

Check symptoms you have noticed since the accident:

☐ Headache	☐ Dizziness	☐ Numbness in toes	☐ Face flushed	☐ Feet cold
☐ Neck pain	☐ Irritability	☐ Depression	☐ Buzzing in ears	☐ Hands cold
☐ Neck stiff	☐ Chest pain	☐ Fatigue	☐ Loss of balance	☐ Stomach upset
☐ Back pain	☐ Head seems to heavy	☐ Shortness of breath	☐ Fainting	☐ Constipation
☐ Nervousness	☐ Pins & needles in arms	☐ Lights bother eyes	☐ Loss of smell	☐ Cold sweats
☐ Tension	☐ Pins & needles in legs	☐ Loss of memory	☐ Loss of taste	☐ Fever
☐ Sleeping problems	☐ Numbness in fingers	☐ Ringing in ears	☐ Diarrhea	☐ _____

Symptoms other then above: _____

GENERAL INFORMATION Have you lost any days from work as a result of this accident? ☐ yes ☐ no

Type of employment? _____ Dates missed: _____

Your insurance company name and address: _____

Insurance company of person responsible for your injuries: _____

Have you been contacted by an insurance adjuster or company representative regarding this claim? ☐ yes ☐ no

Do you have an attorney that has advised you in this case? ☐ yes ☐ no Attorney name: _____

Attorney address: _____ Attorney telephone: _____

_____ _____

Date Patient's Signature