AUTOMOBILE ACCIDENT HISTORY FORM

Date of accident: _____ Time of accident: _____ am/pm

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

_____

_____

_____

Did the police come to the accident scene? YES NO; Is there a report? YES NO
Did you go to a hospital? YES NO

If yes, what is the name and city of the hospital? _____

What did the hospital do for your injuries? _____

Any other Dr's seen? _____

What are your major complaints? _____

Immediate symptoms: _____

Symptoms now: _____

On a scale of 1 – 10 **(with 10 being the worst)** how strong is the pain that you are having? _____

Any complaints in this area before? YES NO
Did you lose consciousness (black out) upon impact? YES NO; how long: _____

Did you become from the accident? **(please circle**) CONFUSED DISORIENTED
LIGHT HEADED DIZZY NAUSEATED BLURRED VISION RING / BUZZ IN EARS

Are you currently suffering from any of the following **(please circle):**
RESTLESSNESS IRRITABILITY DIFFICULT CONCENTRATING DIFFICULT WITH MEMORY
SLEEPLESSNESS FORGETFULNESS REDUCED TOLERANCE TO HEAT

Have you been able to work? YES NO
Was your head pointed straight forward? YES NO
Were you wearing your seat belt? YES NO
Did the vehicles air bag inflate? YES NO

Were you **AWARE** of the approaching accident prior to impact or did impact catch you by **SUPRISE**? **(please circle)**

What is the year, make, and model of **your** vehicle?
Year_____ make_____ model_____

What is the year, make, and model of the **other** vehicle?
Year_____ make_____ model_____

Patient Signature: _____