Automobile Accident History

Name:_____ Date of Birth:_____ M___ F___
Driver's License#_____ Insurance Co:_____
Policy #_____ Claim #_____
Insurance Co. Address: _____ City:_____ State:_____ Zip:_____
Claim Manager Name:_____ Phone #_____ Fax #_____
First Party _____ **Third Party** _____ Have you retained an attorney? _____
Name & Address of Attorney: _____
Do you have a prescription for massage? YES/NO If so, from which physician?_____
_____

GENERAL SYMPTOMS:
Did you hit any part of your body during the collision (i.e. head on dash, chest on steering wheel)? Yes/No If YES, which part & how?_____
_____
Did you receive medical care after the accident? YES/NO Were you hospitalized? YES/NO
If YES, explain:_____
Have you received care from any other healthcare specialist? YES/NO
If YES, name & type of specialist:_____
What type of care were you given?_____ For how long?_____
What are your current symptoms?_____
Have you ever been injured in a similar manner? YES/NO If YES, how & when?_____
_____

ACCIDENT HISTORY:
Date of Accident:_____ Time of Accident:_____ A.M/P.M
In your own words, how did the accident occur?_____
_____
_____
_____
_____
What type of vehicle were you in? Make:_____ Model:_____ Year:_____
Were you: DRIVER/PASSENGER Was it your vehicle? YES/NO If NO, whose?_____
If passenger, position: FRONT/BACK/LEFT/RIGHT/CENTER (circle all that apply)
Were you rotated in the seat? YES/NO Were you reclined in the seat? YES/NO
Were other people in the car? YES/NO If YES, were they injured? YES/NO If YES, please explain:_____
Seat belts: YES/NO Headrest Position?_____Were you awake? YES/NO
Were you under the influence of any substance (alcohol, medications, etc)? YES/NO
How long had you been in the car at the time of the accident? _____
Where were you prior to the accident? _____
What were the traveling conditions?_____ Speed of vehicle?_____MPH
Was your car hit? YES/NO If YES, where was it hit? FRONT/REAR/LEFT SIDE/RIGHT SIDE

What was the damage to your car? (See Below)

Inside:_____

Outside:_____

Did your vehicle strike anything? YES/NO

If YES, was it: ANOTHER CAR/SIGN/BRIDGE/HEDGE/EMBANKMENT/OTHER (please explain:_____ Size & Type:_____

Did you lose consciousness at any time after the accident occurred? YES/NO

Do you remember the impact? YES/NO Did your vehicle go off the road? YES/NO

If YES, where did it go (i.e. ditch, down or up embankment, etc). Please explain:_____

_____

Does it bother you to ride in a car now? YES/NO If YES, as a: DRIVER/PASSENGER

Please state any strange events that happened during or immediately after the accident:____

_____

Have you had any time loss from work? YES/NO If YES, dates: from:_____ to:_____

Do you have any outside help? YES/NO If YES, what type?_____

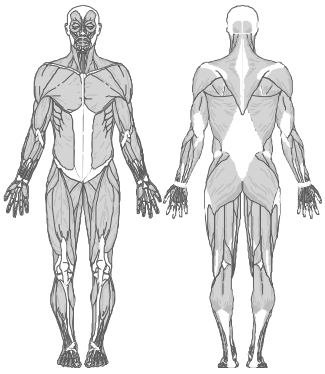
What are you doing to address the pain/symptoms from the accident?

_____

_____

_____

Mark Pain Area: +++ Burning
000 Stabbing
--- Sharp
||| Constant



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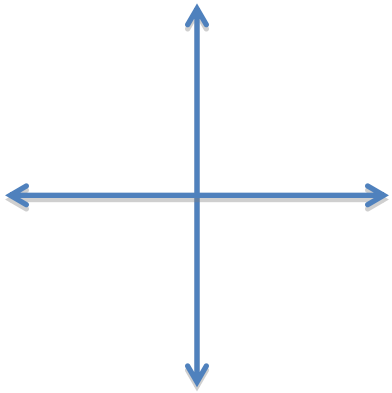

Please Draw Accident

_____ _____ _____

Patient Name (Please Print) Date Patient Signature

_____

Staff Signature