AUTOMOBILE INJURY HISTORY

NAME _____ DATE OF ACCIDENT _____ TIME _____

WHERE DID ACCIDENT HAPPEN? _____

DESCRIBE ACCIDENT IN YOUR OWN WORDS _____

_____

_____

WHAT WAS YOUR POSITION IN CAR? ☐ DRIVER ☐ PASSENGER. IF PASSENGER, WERE YOU SITTING IN ☐ FRONT ☐ RIGHT REAR ☐ LEFT REAR.

DID YOUR VEHICLE STRIKE OTHER VEHICLE? ☐ YES ☐ NO WAS YOUR CAR STRUCK BY OTHER VEHICLE? ☐ YES ☐ NO

WAS THE IMPACT FROM ☐ THE FRONT? ☐ FROM THE RIGHT SIDE? ☐ FROM THE LEFT SIDE? ☐ FROM THE REAR?

AT THE TIME OF IMPACT WERE YOU ☐ LOOKING STRAIGHT AHEAD? ☐ LOOKING RIGHT? ☐ LOOKING LEFT?

WERE BOTH HANDS ON THE STEERING WHEEL? ☐ YES ☐ NO WAS YOUR FOOT ON THE BRAKE ☐ YES ☐ NO

WERE YOU BRACED FOR IMPACT? ☐ YES ☐ NO

WHERE IN THE CAR WERE YOU AFTER THE ACCIDENT? _____

WERE YOU WEARING SEAT BELTS? ☐ YES ☐ NO DID YOU STRIKE ANYTHING IN VEHICLE AT TIME OF IMPACT? ☐ YES ☐ NO

IF YES SPECIFY: ☐ STEERING WHEEL ☐ DASHBOARD ☐ WINDSHIELD ☐ SIDE DOOR ☐ ARM REST ☐ SIDE WINDOW

PLEASE STATE PART OF BODY: ☐ CHEST ☐ CHIN ☐ KNEE ☐ SHOULDER ☐ HAND ☐ HEAD

IMMEDIATELY FOLLOWING THE ACCIDENT, HOW DID YOU FEEL? _____

_____

WERE YOU UNCONSCIOUS? ☐ YES ☐ NO IN A DAZE ☐ YES ☐ NO DID YOU GO TO THE HOSPITAL ☐ YES ☐ NO

IF YOU WENT TO THE HOSPITAL, WHEN? AT TIME OF ACCIDENT ☐ YES ☐ NO NEXT DAY ☐ YES ☐ NO

HOW DID YOU GET TO HOSPITAL? AMBULANCE ☐ YES ☐ NO PRIVATE TRANSPORTATION ☐ YES ☐ NO

DID THE AMBULANCE ATTENDANTS PLACE YOU IN NECK COLLAR? ☐ YES ☐ NO SPLINTS? ☐ YES ☐ NO BRACE? ☐ YES ☐ NO

NAME OF HOSPITAL _____

ATTENDED BY DR. _____ WERE YOU X-RAYED AT HOSPITAL ☐ YES ☐ NO

IF SO, WHAT WAS THE DIAGNOSIS? _____

WERE YOU ADMITTED TO THE HOSPITAL? ☐ YES ☐ NO HOW LONG DID YOU STAY? _____

WHAT TREATMENT WAS RENDERED? _____

DESCRIBE SYMPTOMS FROM THE DAY FOLLOWING ACCIDENT TO TODAY'S DATE _____

_____

WHAT RECOMMENDATIONS WERE MADE? SEE OWN DOCTOR? ☐ YES ☐ NO SEE ORTHOPEDIC DOCTOR? ☐ YES ☐ NO

PHYSICAL THERAPY ☐ YES ☐ NO

BEFORE THE INJURY WERE YOU CAPABLE OF WORKING ON AN EQUAL BASIS WITH OTHERS YOUR AGE? ☐ YES ☐ NO

ARE YOUR WORK ACTIVITIES RESTRICTED AS A RESULT OF THIS ACCIDENT? ☐ YES ☐ NO

IF YES, GIVE PERCENTAGE OF RESTRICTION: _____

ARE YOUR HOME ACTIVITIES RESTRICTED AS A RESULT OF THIS ACCIDENT? ☐ YES ☐ NO

DO YOU HAVE A COPY OF POLICE REPORT? ☐ YES ☐ NO IF YES, PLEASE BRING A COPY TO OUR OFFICE

SIGNATURE _____ DATE _____