

## AUTOMOBILE ACCIDENT HISTORY

Name: \_\_\_\_\_ Today's Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date of Accident: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Time of Accident: \_\_\_\_\_ AM / PM

City Where Accident Occurred: \_\_\_\_\_ Street Name: \_\_\_\_\_

Have you reported this to your insurance company?  Yes  No

Insurance Company Name: \_\_\_\_\_ Policy #: \_\_\_\_\_

Claim #: \_\_\_\_\_ Adjuster Name: \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_

Do you have Med Pay?  Yes  No Limit \_\_\_\_\_

Have you retained an attorney?  Yes  No

Attorney's Name : \_\_\_\_\_ Attorney's Phone #: ( ) \_\_\_\_\_

Were there any witnesses?  Yes  No If so, name(s): \_\_\_\_\_

### Nature of Accident:

Please list: Make \_\_\_\_\_ Model \_\_\_\_\_ Year \_\_\_\_\_ of your vehicle.

Were you:  Driver  Passenger  Front Seat  Back Seat

Number of people in your vehicle? \_\_\_\_\_ Other Vehicle? \_\_\_\_\_

What direction were you headed?  North  East  South  West

on (name of street) \_\_\_\_\_

What direction was the other vehicle headed?  North  East  South  West

on (name of street) \_\_\_\_\_

Were you struck from:  Behind  Front  Left side  Right side

Was there any damage to:  Windshield  R/L side window  R/L side panel

Rear end  Front end  Steering wheel  Other \_\_\_\_\_

What is the estimated cost to repair your vehicle? \_\_\_\_\_

Was your vehicle stopped at the time of impact?  Yes  No If no, estimate speed: \_\_\_\_\_

Were you wearing a seatbelt?  Yes  No

Were you facing forward at the time of impact?  Yes  No

Were you knocked unconscious?  Yes  No If yes, for how long? \_\_\_\_\_

Were police notified?  Yes  No Is there a police report?  Yes  No

In your own words, please describe accident: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Did you have any physical complaints BEFORE THE ACCIDENT?  Yes  No

If yes, please describe in detail: \_\_\_\_\_

Please describe how you felt:

a. DURING the accident: \_\_\_\_\_

b. IMMEDIATELY AFTER the accident: \_\_\_\_\_

c. LATER THAT DAY: \_\_\_\_\_

d. THE NEXT DAY: \_\_\_\_\_

What are your PRESENT complaints and symptoms? \_\_\_\_\_

Do you have any congenital (from birth) factors which relate to this problem?  Yes  No

If yes, please describe: \_\_\_\_\_

Do you have any previous illnesses which relate to this case?  Yes  No

If yes, please describe: \_\_\_\_\_

Have you ever been involved in an accident before?  Yes  No

If yes, please describe, including date(s) and type(s) of accidents, as well as injuries sustained: \_\_\_\_\_

Did you go to the hospital following the accident?  Yes  No

If yes, hospital name and city located? \_\_\_\_\_

How did you get to the hospital? \_\_\_\_\_

Were x-rays taken?  Yes  No If yes, which body parts? \_\_\_\_\_

What type of treatment did you receive? \_\_\_\_\_

Were you hospitalized?  Yes  No If yes, how long? \_\_\_\_\_

Have you ever been treated by another doctor since the accident?  Yes  No

If yes, please list doctor's name and address: \_\_\_\_\_

What type of treatment did you receive? \_\_\_\_\_

Since this injury occurred, are your symptoms:     Improving             Getting Worse             Same

**CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:**

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Headache         | <input type="checkbox"/> Irritability       | <input type="checkbox"/> Face Flushed   | <input type="checkbox"/> Shortness of Breath    |
| <input type="checkbox"/> Feet Cold        | <input type="checkbox"/> Neck Pain          | <input type="checkbox"/> Chest Pain     | <input type="checkbox"/> Fever                  |
| <input type="checkbox"/> Neck Stiff       | <input type="checkbox"/> Dizziness          | <input type="checkbox"/> Fatigue        | <input type="checkbox"/> Numbness in Fingers    |
| <input type="checkbox"/> Loss of Balance  | <input type="checkbox"/> Stomach Upset      | <input type="checkbox"/> Sleep Problems | <input type="checkbox"/> Loss of Memory         |
| <input type="checkbox"/> Depression       | <input type="checkbox"/> Fainting           | <input type="checkbox"/> Constipation   | <input type="checkbox"/> Pins & Needles in Legs |
| <input type="checkbox"/> Back Pain        | <input type="checkbox"/> Nervousness        | <input type="checkbox"/> Cold Sweats    | <input type="checkbox"/> Hands Cold             |
| <input type="checkbox"/> Loss of Smell    | <input type="checkbox"/> Loss of Taste      | <input type="checkbox"/> Tension        | <input type="checkbox"/> Head seems Too Heavy   |
| <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Lights Bother Eyes | <input type="checkbox"/> Diarrhea       | <input type="checkbox"/> Pins & Needles in Arms |
| <input type="checkbox"/> Ears Ring        | <input type="checkbox"/> Other _____        |   |   |

Have you lost time from work as a result of this accident?     Yes             No

If yes, please complete this question.

a. Last Day Worked: \_\_\_\_\_

b. Type of Employment: \_\_\_\_\_

c. Are you being compensated for time lost from work?     Yes             No

If yes, please state type of compensation you are receiving? \_\_\_\_\_

Do you notice any activity restrictions as a result of this injury?     Yes             No

If yes, please describe, in detail: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other pertinent information: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date