

**ACCIDENT HISTORY**

Name: \_\_\_\_\_ M / F Age: \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_ Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Driver's License #: \_\_\_\_\_

**RESPONSIBLE FOR PAYMENT:**

Insurance Company: \_\_\_\_\_ Name Of Agent: \_\_\_\_\_  
Address Of Insurance Company: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Have You Retained an attorney?: **YES / NO** Name of attorney: \_\_\_\_\_  
Address of attorney: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**ACCIDENT HISTORY:**

Date of Accident: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time of Accident: \_\_\_\_\_ **AM / PM**  
State how accident happened in your own words: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

<b>YOUR VEHICLE?</b>	Make and Model: _____	Year _____	Size S / M / L _____
<b>VEHICLE #2?</b>	Make and Model: _____	Year _____	Size S / M / L _____
<b>VEHICLE #3?</b>	Make and Model: _____	Year _____	Size S / M / L _____

Where was your car hit? **FRONT / BACK / LEFT SIDE / RIGHT SIDE / ANGLE** \_\_\_\_\_  
Did you strike another car? **YES / NO** If yes, where did you strike it: **FRONT / BACK / SIDE / ANGLE**  
Did your vehicle strike anything else? **YES / NO** If yes, what? **SIGN / TREE / BRIDGE / HEDGE / WALL  
AN EMBARKMENT / OTHER** \_\_\_\_\_  
What were the traffic conditions? **LIGHT / MODERATE / HEAVY / RUSH HOUR**

What was the posted speed limit? \_\_\_\_\_ Your speed? \_\_\_\_\_ Vehicle #2 speed? \_\_\_\_\_ Vehicle #3 speed? \_\_\_\_\_  
Were you accelerating? **YES / NO**  
Were you driving? **YES / NO** If not, where were you? **PASS. FRONT / REAR DRIVER / REAR PASS**  
Was it your car? **YES / NO** If not, whose? \_\_\_\_\_  
What time of day was it? **DAYLIGHT / NIGHT / DUSK / DAWN**  
What were the road conditions? **DRY / WET / ICY / GRAVEL / CONSTRUCTION**  
Did it happen at a/an: **STOP SIGN / TRAFFIC LIGHT / INTERSECTION / LOCAL ROAD / HIGHWAY**  
Type of road? **2 LANE / 4 LANE / GRAVEL / TAR / OTHER** \_\_\_\_\_

**GENERAL SYMPTOMS:**

What was your pain immediately after the accident?: \_\_\_\_\_  
What is your pain currently?: \_\_\_\_\_  
Did you hit any part of your body during the accident, for example: Head on dash, chest on steering wheel? **YES / NO**  
If yes, which part and how?: \_\_\_\_\_  
\_\_\_\_\_

Were you knocked unconscious? **YES / NO**  
Do you remember the accident? **YES / NO**  
Were you able to drive/operate after the accident? **YES / NO** If no, explain why \_\_\_\_\_  
Where did you go/ taken after the accident? **HOME / WORK / HOSPITAL / OTHER** \_\_\_\_\_  
Did you receive care from any other health care specialist?: **YES / NO** If yes, what is specialist name / practice /  
address: \_\_\_\_\_  
What type of care were you given and for how long?: \_\_\_\_\_  
Have you had any time loss from work? **YES / NO** If yes, from \_\_\_\_\_ to \_\_\_\_\_

**ACCIDENT HISTORY CON'T**

Seat belts on? **YES / NO** Shoulder harness on? **YES / NO**

What position were you facing? **FORWARD / RIGHT / LEFT / UP / DOWN / BACK**

What position was your **backrest** in? **RECLINED / UPRIGHT**

Position of **headrest**? **BELOW EARS / EVEN WITH EARS / ABOVE EARS**

Was your foot on the brake at the time of impact? **YES / NO** If yes, did it come of the brake **YES / NO**

Did you get to react before impact? / Did you see the accident coming? **YES / NO**

If yes, What did you do to prepare for impact? \_\_\_\_\_

Were you tired? **YES / NO** Were you awake? **YES / NO**

How long had you been in the vehicle before the accident? \_\_\_\_\_ **MIN.** \_\_\_\_\_ **HRS**

Where were you prior to the accident? \_\_\_\_\_

Other people in the car? **YES / NO** IF yes, list all names: \_\_\_\_\_

Were they injured? **YES / NO** If yes, explain: \_\_\_\_\_

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

State any strange events that happened during or immediately after the accident. \_\_\_\_\_

In what condition was the vehicle prior to the accident? \_\_\_\_\_

What damage was done to **your** vehicle? \_\_\_\_\_

What was the damage to the **other** vehicle (s)? \_\_\_\_\_

Do you have pictures of the above automobile? **YES / NO** Was accident report made? **YES / NO**

Police of: City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_

Who was ticketed? \_\_\_\_\_ For what? \_\_\_\_\_

N

W

E

S

**PLEASE DRAW THE ACCIDENT**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

\_\_\_\_\_  
Staff Signature

## Duties Under Duress / Loss of Enjoyment

Name: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_\_\_

Are there day to day living duties which are painful or difficult for you to perform as a result of the injuries you sustained in the motor vehicle collision? Are there areas of your life which you normally would be enjoying, but are currently not enjoying, as a result of the motor vehicle collision?

Include those duties/responsibilities which require that you reduce the time you are capable of performing them. Include all instances where you have received lifting, stretching, bending, sitting, standing, walking or other restrictions which affect your performance.

General:	From:	To:	Additional Comments:
<input type="checkbox"/> Walking	_/_/___	_/_/___	_____
<input type="checkbox"/> Sitting	_/_/___	_/_/___	_____
<input type="checkbox"/> Climbing stairs	_/_/___	_/_/___	_____
<input type="checkbox"/> Chewing	_/_/___	_/_/___	_____
<input type="checkbox"/> Getting in/out of auto	_/_/___	_/_/___	_____
<input type="checkbox"/> Kneeling	_/_/___	_/_/___	_____
<input type="checkbox"/> Sleeping	_/_/___	_/_/___	_____
<input type="checkbox"/> Standing	_/_/___	_/_/___	_____
<input type="checkbox"/> Lifting children	_/_/___	_/_/___	_____
<input type="checkbox"/> Reading	_/_/___	_/_/___	_____
<input type="checkbox"/> Swimming	_/_/___	_/_/___	_____
<input type="checkbox"/> Playing piano	_/_/___	_/_/___	_____
<input type="checkbox"/> Sexual intercourse	_/_/___	_/_/___	_____
<input type="checkbox"/> Using telephone	_/_/___	_/_/___	_____
<input type="checkbox"/> Running	_/_/___	_/_/___	_____
<input type="checkbox"/> Bending	_/_/___	_/_/___	_____
<input type="checkbox"/> Lying in bed	_/_/___	_/_/___	_____
<input type="checkbox"/> Using typewriter/computer	_/_/___	_/_/___	_____
<input type="checkbox"/> Exercising	_/_/___	_/_/___	_____
<input type="checkbox"/> Sitting in recliner	_/_/___	_/_/___	_____
<b>Housework:</b>			
<input type="checkbox"/> Doing Laundry	_/_/___	_/_/___	_____
<input type="checkbox"/> Making beds	_/_/___	_/_/___	_____
<input type="checkbox"/> Vacuuming	_/_/___	_/_/___	_____
<input type="checkbox"/> Washing dishes	_/_/___	_/_/___	_____
<input type="checkbox"/> Ironing	_/_/___	_/_/___	_____
<input type="checkbox"/> Carrying groceries	_/_/___	_/_/___	_____
<input type="checkbox"/> Caring for pets	_/_/___	_/_/___	_____
<input type="checkbox"/> Cooking	_/_/___	_/_/___	_____
<b>Yard work:</b>			
<input type="checkbox"/> Mowing the lawn	_/_/___	_/_/___	_____
<input type="checkbox"/> Raking leaves	_/_/___	_/_/___	_____
<input type="checkbox"/> Gardening	_/_/___	_/_/___	_____
<input type="checkbox"/> Working in the yard	_/_/___	_/_/___	_____
<b>Personal Grooming:</b>			
<input type="checkbox"/> Combing hair	_/_/___	_/_/___	_____
<input type="checkbox"/> Shaving	_/_/___	_/_/___	_____
<input type="checkbox"/> In/out bathtub	_/_/___	_/_/___	_____
<input type="checkbox"/> Brushing teeth	_/_/___	_/_/___	_____
<b>Travel:</b>			
<input type="checkbox"/> Driving	_/_/___	_/_/___	_____
<input type="checkbox"/> Riding (Passenger)	_/_/___	_/_/___	_____