AUTOMOBILE ACCIDENT HISTORY

Name _____

Date of accident _____ Location_____

Please DRAW and WRITE how accident happen _____

_____

_____

Were you the: ☐ Driver ☐ Front Passenger ☐ Back Passenger ☐ Pedestrian ☐ Bicyclist

Type and Size of your car _____ Other car _____

Your car's speed: ☐ Stopped ☐ 10 MPH ☐ 20 MPH ☐ 30 MPH ☐ 40 MPH ☐ ≥50 MPH

Other car's speed: ☐ ≤10 MPH ☐ 20 MPH ☐ 30 MPH ☐ 40 MPH ☐ 50 MPH ☐ ≥60 MPH

Road Conditions: ☐ Clear ☐ Wet ☐ Foggy ☐ Icy ☐ Snowy ☐ Congestion ☐ Other

Type of accident: ☐ Rear impact ☐ Front impact ☐ Side impact ☐ Roll over ☐ Other

Head and body position at time of accident: ☐ Straight ☐ Right ☐ Left ☐ Unsure

Did you see the accident before it occurred? ☐ No ☐ Yes Seatbelts on? ☐ No ☐ Yes

Amount it costs to fix your car $ _____ Airbag deploy? ☐ No ☐ Yes

Were you disoriented or loss consciousness after the accident? ☐ Yes ☐ No ☐ Not Sure

Part of body hit inside the car? ☐ None ☐ Chest ☐ Head ☐ Hand ☐ Knee ☐ Other

When did you feel pain? ☐ Immediately ☐ Few hours later ☐ Next day ☐ Few days later

Did you go to hospital or urgent care? ☐ No ☐ Yes Name of facility _____

If yes, when? ☐ Immediately after the accident ☐ Later that day ☐ Next day ☐ Few days later

How did you get there? ☐ Self ☐ Ambulance ☐ Family ☐ Friends ☐ Police

List all your symptoms _____

Have you missed any time from work? ☐ No ☐ Yes If yes, how many day(s) off? _____ day(s)

Have you contacted your own insurance company about this accident? ☐ Yes ☐ No

Your auto insurance company _____ Claim # _____

Insurance company of other driver _____ Claim # _____

Adjuster's name _____ Adjuster's phone # _____

Name of driver who hit/drove you _____

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PATIENT'S SIGNATURE _____ DATE_____