

HISTORY OF MOTOR VEHICLE INJURY

Patient _____ Phone # _____

DOB _____ SS# _____

Date of Accident _____ Time of Accident _____ am pm

What type of motor vehicle injury was this? Auto vs. Auto Auto vs. Pedestrian
 Auto vs. Bicycle Auto vs. Motorcycle Other _____

Were you the: Driver Passenger Were there other people in the care with you? Yes No

Make/Model of vehicle you were in: _____ Year _____

If unknown, please select the following that apply: Older Newer Compact Midsize
 SUV Motorcycle Bicycle Pedestrian Other _____

Was the impact to your vehicle: Head-on On the left On the right From the rear

Was the force of the collision: Major Moderate Other _____

Describe in detail how the accident occurred: _____

Where you wearing your seatbelt? Yes No With a shoulder strap? Yes No

Were you aware the collision was about to take place prior to impact? Yes No

Did you have time to brace yourself before impact? Yes No

Where you looking: Straight ahead In the rearview mirror Left Right Don't remember

Did your head strike anything in the vehicle? No Yes, Please describe _____

Were you knocked unconscious? Yes No For how long? _____

What were the road conditions? Dry Wet Icy Snow Other _____

How long after the collision did you begin to experience symptoms? Immediately
 Few minutes Few hours Same evening Few days Other _____

Did you receive treatment from any other physicians before coming to our office? Yes No
If so, from whom? _____

What treatment did you receive? _____

Are you currently taking any medications? Yes No

If yes, please list medications: _____

Has the injury caused you any loss or alteration of your normal work or leisure activities?
 Yes No If yes, please describe: _____

Are you represented by an attorney? Yes No

Attorney Name _____

Street Address _____ City _____ St _____ Zip _____

Phone _____ Fax _____

Patient Signature _____ Date _____