

# Motor Vehicle Accident History

PATIENT NAME:		DATE:	
ADDRESS:		CITY:	STATE/ZIP CODE:
HOME PHONE NUMBER:		CELL PHONE NUMBER:	
SOCIAL SECURITY NUMBER:	DATE OF BIRTH:	AGE:	GENDER:
EMERGENCY CONTACT NAME:		EMERGENCY CONTACT PHONE NUMBER:	
EMPLOYER NAME:		EMPLOYER ADDRESS:	

## ACCIDENT INFORMATION

DATE OF ACCIDENT:	TIME OF ACCIDENT:	WHERE WERE YOU LOCATED IN THE VEHICLE AT THE TIME OF THE ACCIDENT? <input type="checkbox"/> DRIVER <input type="checkbox"/> PASSENGER <input type="checkbox"/> FRONT SEAT <input type="checkbox"/> BACK SEAT	
NUMBER OF PEOPLE IN THE CAR:	NAMES OF PEOPLE IN THE CAR WITH YOU:		
WHAT DIRECTION WAS YOUR CAR HEADED? <input type="checkbox"/> NORTH <input type="checkbox"/> SOUTH <input type="checkbox"/> EAST <input type="checkbox"/> WEST		ON WHAT STREET WERE YOU HEADED?	
WHAT DIRECTION WAS THE OTHER CAR HEADED? <input type="checkbox"/> NORTH <input type="checkbox"/> SOUTH <input type="checkbox"/> EAST <input type="checkbox"/> WEST		WERE YOU STRUCK FROM: <input type="checkbox"/> BEHIND <input type="checkbox"/> FRONT <input type="checkbox"/> LEFT SIDE <input type="checkbox"/> RIGHT SIDE	
WERE YOU KNOCKED UNCONSCIOUS? <input type="checkbox"/> YES <input type="checkbox"/> NO		DID YOU HIT YOUR HEAD? <input type="checkbox"/> YES <input type="checkbox"/> NO	
WHERE WERE YOU TAKEN AFTER THE ACCIDENT?			BY AMBULANCE: <input type="checkbox"/> YES <input type="checkbox"/> NO
WERE THE POLICE ON THE SCENE? <input type="checkbox"/> YES <input type="checkbox"/> NO	WAS A REPORT FILED? <input type="checkbox"/> YES <input type="checkbox"/> NO	DO YOU HAVE A COPY? <input type="checkbox"/> YES <input type="checkbox"/> NO	
HAVE YOU BEEN TREATED BY ANY OTHER DOCTORS FOR THIS ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		SINCE THE INJURY, ARE YOUR SYMPTOMS: <input type="checkbox"/> IMPROVING <input type="checkbox"/> GETTING WORSE <input type="checkbox"/> GETTING BETTER	
HAVE YOU LOST TIME FROM WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		DATE YOU LEFT WORK:	DATE YOU RETURNED TO WORK:
HAVE YOU BEEN INVOLVED IN AN ACCIDENT IN THE PAST? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, PLEASE DESCRIBE:	
DO YOU HAVE ANY PREVIOUS ILLNESSES WHICH RELATE TO THIS CASE? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, PLEASE DESCRIBE:	
DO YOU HAVE ANY ACTIVITY RESTRICTIONS AS A RESULT OF THIS INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, PLEASE DESCRIBE:	

## INSURANCE INFORMATION

AUTO INSURANCE COMPANY NAME:	
ADJUSTER NAME:	ADJUSTER PHONE NUMBER:
POLICY NUMBER:	CLAIM NUMBER:

What is your chief complaint: \_\_\_\_\_

When did your symptoms first appear? \_\_\_\_\_

Is this condition: Getting Worse Stays the Same Comes and Goes Unbearable

Rate the severity of your discomfort on a scale of 0-10, 10 being the most discomfort/severe: 0 1 2 3 4 5 6 7 8 9 10

What type of pain are you experiencing?

Sharp Dull Throbbing Ache Shooting Tingling  
Numbness Stiff

Does it interfere with your: Work Sleep Daily Routine

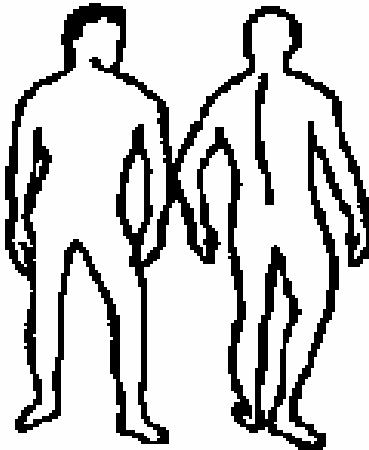
Activities or movements that are difficult to perform:

Sitting Standing Walking Bending Lying Down

Is pain radiating: Y / N. If Yes, Where:

R. Arm L. Arm R. Leg L. Leg

Mark an "X" on the picture where you continue to



Additional complaint: \_\_\_\_\_

When did your symptoms first appear? \_\_\_\_\_

Is this condition: Getting Worse Stays the Same Comes and Goes Unbearable

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What type of pain are you experiencing?

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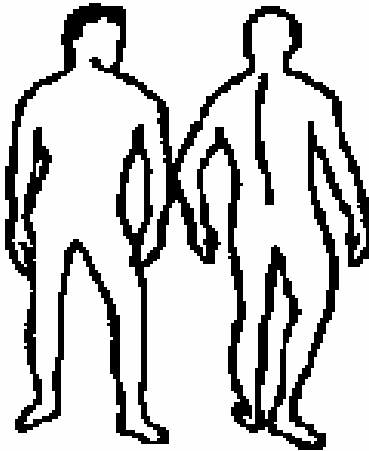
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Is pain radiating: Y / N. If Yes, Where:

R. Arm L. Arm R. Leg L. Leg

Mark an "X" on the picture where you continue to



Additional complaint: \_\_\_\_\_

When did your symptoms first appear? \_\_\_\_\_

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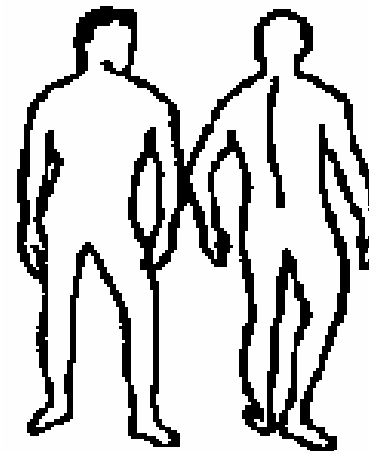
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R. Arm L. Arm R. Leg L. Leg

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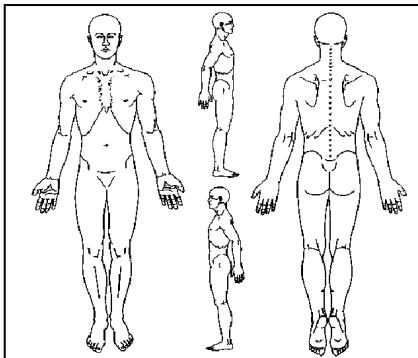
**ACCIDENT INFORMATION**

DESCRIBE THE ACCIDENT IN YOUR OWN WORDS:

INSTRUCTIONS: CHECK (✓) ANY/ALL SYMPTOMS NOTED AFTER THE ACCIDENT.

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> HEADACHE          | <input type="checkbox"/> DIZZINESS              | <input type="checkbox"/> LIGHT BOTHERS EYES |
| <input type="checkbox"/> NECK PAIN         | <input type="checkbox"/> HEAD SEEMS HEAVY       | <input type="checkbox"/> LOSS OF MEMORY     |
| <input type="checkbox"/> NECK STIFFNESS    | <input type="checkbox"/> PINS & NEEDLES IN ARMS | <input type="checkbox"/> EARS RING          |
| <input type="checkbox"/> SLEEPING PROBLEMS | <input type="checkbox"/> PINS & NEEDLES IN LEGS | <input type="checkbox"/> FACE FLUSHED       |
| <input type="checkbox"/> BACK PAIN         | <input type="checkbox"/> NUMBNESS IN FINGERS    | <input type="checkbox"/> BUZZING IN EARS    |
| <input type="checkbox"/> NERVOUSNESS       | <input type="checkbox"/> NUMBNESS IN TOES       | <input type="checkbox"/> LOSS OF BALANCE    |
| <input type="checkbox"/> TENSION           | <input type="checkbox"/> SHORTNESS OF BREATH    | <input type="checkbox"/> FAINTING           |
| <input type="checkbox"/> IRRITABILITY      | <input type="checkbox"/> FATIGUE                | <input type="checkbox"/> LOSS OF SMELL      |
| <input type="checkbox"/> CHEST PAIN        | <input type="checkbox"/> DEPRESSION             | <input type="checkbox"/> LOSS OF TASTE      |
| <input type="checkbox"/> DIARRHEA          | <input type="checkbox"/> FEET FEEL COLD         | <input type="checkbox"/> UPSET STOMACH      |
| <input type="checkbox"/> CONSTIPATION      | <input type="checkbox"/> HANDS FEEL COLD        | <input type="checkbox"/> OTHER: _____       |
| <input type="checkbox"/> FEVER             | <input type="checkbox"/> COLD SWEATS            | <input type="checkbox"/> OTHER: _____       |

INSTRUCTIONS: Please mark the area and type of pain on the drawings using the codes listed below:  
N=Numbness P=Pain A=Ache T=Tingling S=Stiffness/Soreness



COMMENTS:

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PLEASE PROVIDE ANY OTHER PERTINENT INFORMATION YOU THINK WE SHOULD KNOW:

**DOCTOR ONLY**

DOCTOR COMMENTS:

**SIGNATURE**

PATIENT SIGNATURE:

DATE: