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** ______________________