Motor Vehicle Accident History

Name:____Phone:___________________

Address: ________________________________City:______________State______Zip_______

Age:_________D.O.B._____________ M / F SS#___________________________________

Emergency Contact:____

Employers Name & Address:____

Nature of Accident:

Date Of Accident:____Time:_______________

Where were you: **a) Driver b) Passenger c) Front Seat d) Back Seat**

Number of people in your car: ______

Names of people in the car with you:____

____

What direction were you headed: **a) North b) South c) East d) West**

On what street?____

What direction was the other car headed: **a) North b) South c) East d) West**

Were your struck from: **a) Behind b) Front c) Left Side d) Right Side**

Were you knocked unconscious? **Yes No** Did you hit your head? **Yes No**

Where were you taken after the accident?_______________________________________

By Ambulance? **Yes No** What did they do for you?_________________________

Were the police on the scene? **Yes No** Was a report filed? **Yes No**

Do you have a copy? **Yes No**

Have you been treated by any other doctors for this injury or accident?

____

Since the injury, are your symptoms: **Improving Getting Worse Getting Better**

Have you lost time from work? **Yes No** Date you Left: ________Returned?_______

Have you been involved in an accident in the past?______________________________

Describe:____

Do you have any previous illnesses which relate to this case? **Yes No**

If Yes, describe____

Do you notice any activity restrictions as a result of this injury? **Yes No**

If yes, describe____

____

Circle **ANY / ALL** symptoms noted after the accident:

Headache	*Dizziness*	*Light bothers eyes*
Neck pain	*Head seems heavy*	*Loss of memory*
Neck stiffness	*Pins & needles in arms*	*Ears ring*
Sleeping problems	*Pins & needles in legs*	*Face Flushed*
Back pain	*Numbness in fingers*	*Buzzing in ears*
Nervousness	*Numbness in toes*	*Loss of balance*
Tension	*Shortness of breath*	*Fainting*
Irritability	*Fatigue*	*Loss of smell*
Chest pain	*Depression*	*Loss of taste*
Diarrhea	*Feet cold*	*Hands cold*
Loss of taste	*Hands cold*	*Stomach upset*
Constipation	*Cold sweats*	*Fever*

Other pertinent information:____

____

____

Insurance Information:

Your insurance company:_______________________________Phone:________________

Adjuster(s) Name:_________________________________Phone:______________________

Policy #____________________________________Claim #___________________________

Signature:____Date:___________________