If your injuries could be due to an auto accident, please fill out this page.

ACCIDENT PATIENT HISTORY

Patient Name: _____
Place of Accident: _____
Date of Accident: _____ Time:_____

Were you: ☐ Driver ☐ Passenger ☐ Front Seat ☐ Back Seat

Were you wearing a seat belt? ☐ Yes ☐ No

DESCRIPTION OF ACCIDENT:

Were you struck: ☐ From Behind ☐ In Front ☐ Right Front ☐ Right Middle

☐ Right Rear ☐ Left Front ☐ Left Middle ☐ Left Rear

Were you: ☐ Moving ☐ Stopped ☐ Turning Right ☐ Turning Left

Approximate speed of automobiles at impact: Yours_____ mph Other _____mph

Did you see the accident coming? ☐ Yes ☐ No

Which way were you looking at impact? _____

Upon impact which way was your body thrown? ☐ Forward ☐ Backward ☐ Right ☐ Left

Did you hit your head on anything? ☐ Yes ☐ No What? _____

Lose consciousness? ☐ Yes ☐ No How Long? _____

Type of vehicle you were in _____ Amount of damage _____

Type of other vehicle _____ Amount of damage _____

Police report filed? ☐ Yes ☐ No

Citation Issued? ☐ Yes ☐ No To whom? _____

TREATMENT RECEIVED

When did the pain begin?

_____

Since MVA – pain is: ☐ Less ☐ Same ☐ Worse

Transported to Hospital? ☐ Yes ☐ No

By Whom? ☐ Self ☐ Ambulance ☐ Air Ambulance

Which Hospital? _____

X-rays Taken? ☐ Yes ☐ No What X-rays? _____

Have you seen another Dr. since the MVA? ☐ Yes ☐ No

Dr. Name _____ Where _____

What treatment did you receive? _____