Patient name:______________________

Date of Birth: ___ / ___ / _____

Auto Accident History

Today's Date: ____/_____/____

Accident Date: ____/_____/____

Circle the answer for each question to insure the best treatment and most accurate reports to the insurance.

Symptom History

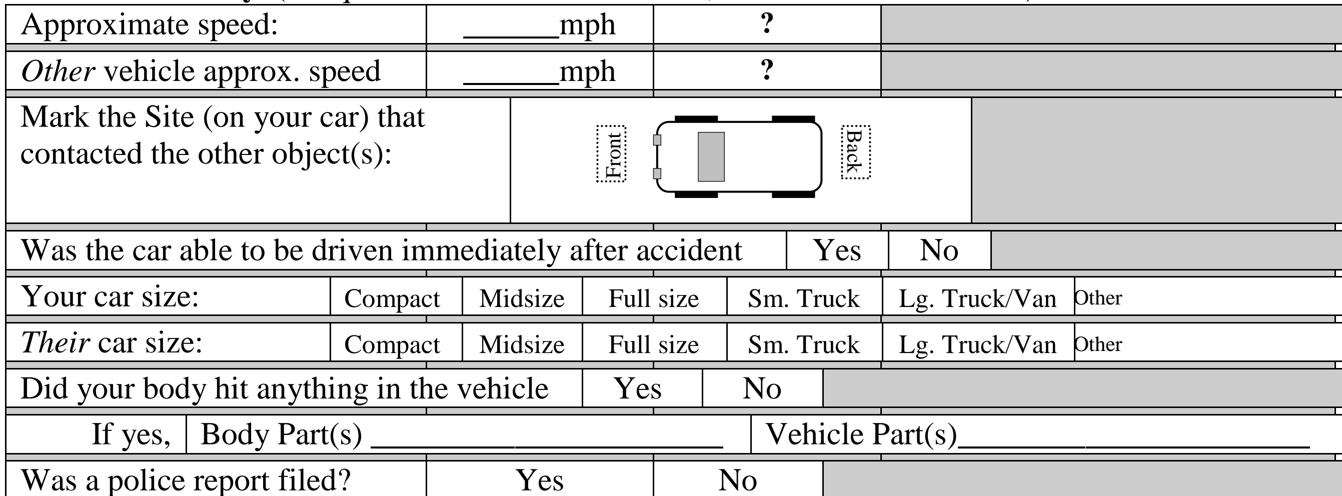
Body Part (incl. Lt or Rt)	Symptom (dizzy, pain, ache, tingling, etc.)	When did symptom begin? (circle one) (approximately how many)	My symptom is now…	Office Use FREQ	Severity **now** 0 = None 10 = worst imaginable	Office Use Prior Severity
		Immediate / __hrs / ____days	Worse / Same / Better / Gone	C I F O	**0 1 2 3 4 5 6 7 8 9 10**	
		Immediate / __hrs / ____days	Worse / Same / Better / Gone	C I F O	**0 1 2 3 4 5 6 7 8 9 10**	
		Immediate / __hrs / ____days	Worse / Same / Better / Gone	C I F O	**0 1 2 3 4 5 6 7 8 9 10**	
		Immediate / __hrs / ____days	Worse / Same / Better / Gone	C I F O	**0 1 2 3 4 5 6 7 8 9 10**	
		Immediate / __hrs / ____days	Worse / Same / Better / Gone	C I F O	**0 1 2 3 4 5 6 7 8 9 10**	
		Immediate / __hrs / ____days	Worse / Same / Better / Gone	C I F O	**0 1 2 3 4 5 6 7 8 9 10**	

Were you rendered unconscious?	Yes	No	If yes, ___minutes or ____hours
Circle any you have experienced: [if early, possible CT]	Amnesia, Forgot things	Unusual confusion	Less Alert
How did you leave the accident?	Drove	Passenger	Ambulance
Have you been treated for these symptoms?	Yes	No	by Who? ______________________________
--circle all that you received	x-rays	medications	other________________________________

Body Position upon Impact

Where were you seated?	Driver	Front Passenger	Back Left	Back Right	
Were you wearing a Seatbelt?	Yes	No			
Was your headrest high enough?	Yes	No			
Head Position…Looking…	Left	Forward	Right	Unknown	Other
Were you aware of impending impact?	Yes	No			

IMPACT History (All questions refer to **YOUR** car, unless stated otherwise.)



Approximate speed:	______mph	**?**				
Other vehicle approx. speed	______mph	**?**				
Mark the Site (on your car) that contacted the other object(s):	Front / Back					
Was the car able to be driven immediately after accident	Yes	No				
Your car size:	Compact	Midsize	Full size	Sm. Truck	Lg. Truck/Van	Other
Their car size:	Compact	Midsize	Full size	Sm. Truck	Lg. Truck/Van	Other
Did your body hit anything in the vehicle	Yes	No				
If yes,	Body Part(s) ______________________	Vehicle Part(s)______________________				
Was a police report filed?	Yes	No				

Miscellaneous

Has your insurance been contacted?	Yes	No	
Have you contacted an attorney?	Yes	No	If so, who? ____________________________

Abbrev Key – C – Constant, I – Intermittent (Several times each day or often during a certain activity), F – Frequent (Multiples times or hours per day or each time during a common activity), O – Occasional (Sometimes or minutes per day or each time during a uncommon activity)

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