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

ACCIDENT PATIENT HISTORY

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? ____