



MOTOR VEHICLE ACCIDENT HISTORY

PATIENT NAME:		DATE:	
ADDRESS:		CITY:	STATE/ZIP CODE:
HOME PHONE NUMBER:		CELL PHONE NUMBER:	
SOCIAL SECURITY NUMBER:	DATE OF BIRTH:	AGE:	GENDER:
EMERGENCY CONTACT NAME:		EMERGENCY CONTACT PHONE NUMBER:	
EMPLOYER NAME:		EMPLOYER ADDRESS:	
ACCIDENT INFORMATION			
DATE OF ACCIDENT:	TIME OF ACCIDENT:	WHERE WERE YOU LOCATED IN THE VEHICLE AT THE TIME OF THE ACCIDENT? <input type="checkbox"/> DRIVER <input type="checkbox"/> PASSENGER <input type="checkbox"/> FRONT SEAT <input type="checkbox"/> BACK SEAT	
NUMBER OF PEOPLE IN THE CAR:	NAMES OF PEOPLE IN THE CAR WITH YOU:		
WHAT DIRECTION WAS YOUR CAR HEADED? <input type="checkbox"/> NORTH <input type="checkbox"/> SOUTH <input type="checkbox"/> EAST <input type="checkbox"/> WEST		ON WHAT STREET WERE YOU HEADED?	
WHAT DIRECTION WAS THE OTHER CAR HEADED? <input type="checkbox"/> NORTH <input type="checkbox"/> SOUTH <input type="checkbox"/> EAST <input type="checkbox"/> WEST		WERE YOU STRUCK FROM: <input type="checkbox"/> BEHIND <input type="checkbox"/> FRONT <input type="checkbox"/> LEFT SIDE <input type="checkbox"/> RIGHT SIDE	
WERE YOU KNOCKED UNCONSCIOUS? <input type="checkbox"/> YES <input type="checkbox"/> NO		DID YOU HIT YOUR HEAD? <input type="checkbox"/> YES <input type="checkbox"/> NO	
WHERE WERE YOU TAKEN AFTER THE ACCIDENT?:			BY AMBULANCE: <input type="checkbox"/> YES <input type="checkbox"/> NO
WERE THE POLICE ON THE SCENE? <input type="checkbox"/> YES <input type="checkbox"/> NO	WAS A REPORT FILED? <input type="checkbox"/> YES <input type="checkbox"/> NO	DO YOU HAVE A COPY? <input type="checkbox"/> YES <input type="checkbox"/> NO	
HAVE YOU BEEN TREATED BY ANY OTHER DOCTORS FOR THIS INJURY/ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	SINCE THE INJURY, ARE YOUR SYMPTOMS: <input type="checkbox"/> IMPROVING <input type="checkbox"/> GETTING WORSE <input type="checkbox"/> GETTING BETTER		
HAVE YOU LOST TIME FROM WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE YOU LEFT WORK:	DATE YOU RETURNED TO WORK?	
HAVE YOU BEEN INVOLVED IN AN ACCIDENT IN THE PAST? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, PLEASE DESCRIBE:		
DO YOU HAVE ANY PREVIOUS ILLNESSES WHICH RELATE TO THIS CASE? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, PLEASE DESCRIBE:		
DO YOU HAVE ANY ACTIVITY RESTRICTIONS AS A RESULT OF THIS INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, PLEASE DESCRIBE:		
INSURANCE INFORMATION			
INSURANCE COMPANY NAME:		INSURANCE COMPANY PHONE:	
ADJUSTER NAME:		ADJUSTER PHONE:	
POLICY NUMBER:		CLAIM NUMBER:	

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