CAR ACCIDENT HISTORY FORM

NAME: _____
DATE OF ACCIDENT: _____ **TIME:** _____
LOCATION OF ACCIDENT: _____
INSURANCE COMPANY: _____ **CLAIM #:** _____
YOUR CAR: YEAR_____ **MAKE**_____ **MODEL**_____
OTHER CAR INVOLVED: YEAR_____ **MAKE**_____ **MODEL** _____
Please give a brief description of the accident:

Were you the driver?	Yes	No		
Passenger in front?	Yes	No		
Passenger in rear?	Yes	No		
Were you wearing a seatbelt?	Yes	No	Lap Restraint Only	Lap & Shoulder Restraint
Does your car have headrests?	Yes	No		
Were they fully extended?	Yes	No		
Did the airbags deploy?	Yes	No		
Was the collision "Rear End"?	Yes	No		

Right front _____ Left front _____
Right side _____ Left side _____
Other _____

Did you see it coming?	Yes	No
Did you brace yourself?	Yes	No
Was your head turned?	Yes	No

What direction? _____

Did you strike your head?	Yes	No

What part of the car?_____

Did the police respond?	Yes	No

What was the estimated speed upon impact? _____

Did you lose consciousness?	Yes	No
Were you dazed?	Yes	No
Were you dizzy?	Yes	No
Were you nauseated?	Yes	No
Were you examined at the scene by paramedics or other medical personnel?	Yes	No
Did you go to the hospital?	Yes	No

By Ambulance? _____ By car _____

Did they take x-rays?	Yes	No

Did they tell you a diagnosis? Yes No
Diagnosis you were told _____
What were your symptoms at the scene of the accident
Did you have cuts or bruises? Yes No
Did you go home? _____ To work?_____ Other_____
How did your symptoms change later the same day or evening?
Did they worsen? Yes No
Did you notice more symptoms? Yes No
How did they differ from those at the scene of the accident?

Did you take medication? Yes No
What kind? _____
What are your symptoms now?

Have you had any bowel or bladder
difficulties since the accident? Yes No

Have you ever been treated for
neck pain prior to this accident? Yes No
If yes, when_____
By whom _____

Have you ever been treated for
mid-back pain prior to this accident? Yes No
If yes, when_____
By whom _____

Have you ever been treated for
low back pain prior to this accident? Yes No
If yes, when _____
By whom _____

Have you ever been treated for any
other injuries (i.e. shoulder, knee, etc.)
prior to this accident? Yes No
If yes, when _____
By whom _____

Have you had prior auto accidents? Yes No
If yes, when_____
Were you treated for injuries from
this accident? Yes No
Please describe this accident and any injuries and treatment you received as a result of this accident: