

AUTOMOBILE ACCIDENT HISTORY

Name: _____ Age: _____ Date of Birth: _____ M F

Address: _____

City: _____ State: _____ Zip: _____

SS#: _____ Driver's License #: _____

Insurance Company: _____ Name of Agent: _____

Address of Insurance Company: _____

Have you retained an attorney? Yes No Name and Address of Attorney: _____

GENERAL SYMPTOMS:

Did you hit any part of your body during the collision, for example: head on dash, chest on steering wheel? Yes No

If yes, which part and how? _____

Where were you taken after the accident? _____

Were you hospitalized? Yes No If yes, for how long? _____

Did you receive care from any other health care specialist? Yes No If yes, what is the specialist's name? _____

What type of care were you given and for how long? _____

Where did you feel the pain? _____

What are your current symptoms? _____

Have you ever been injured in a similar manner? Yes No If yes, how and when? _____

ACCIDENT HISTORY:

Date of Accident: _____ Time of Accident: _____ A.M. P.M.

State how accident happened in you own words: _____

What type of vehicle were you in? Make: _____ Year: _____

Were you driving? Yes No Was it your car? Yes No If not, whose? _____

Passenger? Front Back Right Side Left Side Were you rotated in seat? Yes No

Were you reclined? Yes No Other: _____

Other people in car? Yes No Names and Addresses: _____

Were they injured? Yes No If yes, explain: _____

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