Patients Name_____ Date_____

AUTO ACCIDENT INFORMATION

Current chief complaints (related to accident/injury/disability):

_____

_____

_____

Date of accident / injury / start of disablity :_____

Type of claim: Motor vehicle accident_____
Other_____

Type of vehicle:_____

If motor vehicle accident, were you: driver _____, passenger____

Was the vehicle hit from: front_____, rear_____, right side_____, left side_____

Were you wearing seat belt? Yes_____ No____

Areas of injury: Head_____, Neck_____, Back_____, Other_____

_____

Did you lose consciousness: No_____, Yes_____, For how long_____

Did you go to a hospital/ER? No, Yes_____, date_____

If yes, did you go by ambulance? No_____, Yes_____

Name of hospital:_____

Were x-rays taken in hospital/ER? No_____, Yes_____

If yes, what part of body were x-rays taken:_____

_____

What were the results: _____

What treatment did you receive in hospital/ER?_____

_____

Since the accident/injury, have your symptoms become: completely recovered_____, better_____, unchanged_____, worse_____

Due to the accident/injury, what are your current symptoms? None_____, weakness in arms____, back_____,

weakness in legs_____, back pain_____, neck pain_____, numbness_____, if so where_____

Did you ever have a similar condition/accident?_____

Are you: right handed_____, left handed_____