MOTOR VEHICLE ACCIDENT/INJURY HISTORY

Date _____

Name _____ Date of Birth _____ Age _____

Please read each question carefully and answer all that apply to your most recent work-related accident.

ACCIDENT DESCRIPTION

Date of Accident / Injury _____ Time of Accident _____ AM / PM

Accident was due to: ☐ Multiple Vehicle Accident ☐ Single Vehicle Accident ☐ Pedestrian ☐ Other

Where did the accident/injury happen? (street / intersection / highway, etc.) _____

_____

The road conditions were: ☐ Dry ☐ Wet ☐ Snow/Ice ☐ Other _____

Were there any witnesses? ☐ Yes ☐ No

Name(s) _____

Addresses(es)/Phone(s) _____

In your own words, please describe how the accident occurred _____

_____

_____

INJURY DETAIL

Were you the: ☐ Driver ☐ Passenger ☐ Pedestrian

If you were the passenger, which position were you in? ☐ Front ☐ Right Rear ☐ Left Rear ☐ Other

Was the impact from the: ☐ Front End ☐ Front Left ☐ Front Right ☐ Right Side
☐ Rear End ☐ Rear Left ☐ Rear Right ☐ Left Side

At impact, were you looking: ☐ Left ☐ Right ☐ Straight

Were you aware that the accident was going to occur? ☐ Yes ☐ No

Were you hands on the steering wheel? ☐ Yes ☐ No Was your foot on the brake? ☐ Yes ☐ No

Did your seat have a headrest? ☐ Yes ☐ No If yes, at what level? ☐ Head ☐ Mid Neck ☐ Below Neck

Were you braced for impact? ☐ Yes ☐ No

Were you wearing a seat belt? ☐ Yes ☐ No If yes, was it ☐ Lap belt only ☐ Lap/shoulder combination

Where were you in the car after the accident? _____

Did you strike anything in the car? ☐ Yes ☐ No

If yes, specify: ☐ Steering Wheel/Air Bag ☐ Dashboard ☐ Windshield ☐ Door
☐ Other _____

What body parts were involved? ☐ Chest ☐ Knee ☐ Shoulder ☐ Hand ☐ Foot
☐ Hip ☐ Back ☐ Other _____

Were paramedics or an ambulance present at the scene? ☐ Yes ☐ No

Patient Name _____ Date _____

Were you taken to the hospital/urgent care facility? ☐ Yes ☐ No

Name and Address of hospital/urgent care facility _____

_____

Were X-rays taken? ☐ Yes ☐ No Date of X-rays _____

Where were X-rays taken? _____

EMPLOYMENT / TREATMENT STATUS

Last Date Worked _____ Are you off work now? ☐ Yes ☐ No

Have you lost time from work as a result of this accident? ☐ Yes ☐ No

If yes, are you being compensated for time lost from work? ☐ Yes ☐ No

Has modified work or a reduced work load been offered to you as the result of your injuries? ☐ Yes ☐ No

Patient Name _____ Date _____

PAST MEDICAL TREATMENT

Have you been treated by another doctor for this accident? ☐ Yes ☐ No

If yes, please list the doctor's name and address _____

_____

What type of treatment did you receive? _____

How long were you treated by this doctor? _____

Since your accident, are you: ☐ Improved ☐ Unchanged ☐ Getting Worse

What types of medications are you taking? _____

Do these medications help? ☐ Yes ☐ No ☐ Unknown

Have you had any physical therapy or chiropractic care? ☐ Yes ☐ No

If yes, how often? ☐ Daily ☐ Every other day ☐ Several times a week ☐ Weekly
☐ Every other week ☐ Monthly ☐ Other _____

Does/did physical therapy/chiropractic care help? ☐ Yes ☐ No ☐ Don't know

Have you ever had any past Motor Vehicle Accidents / Workers Compensation Injuries? ☐ Yes ☐ No

If yes, please describe _____

_____

Family Physician _____ Phone _____

Other significant Medical History _____

_____

Additional Comments/Concerns _____

By my signature below, I am verifying that the above information is true to the best of my knowledge.

_____ _____

Patient Signature Date