Auto Accident History Form

Name____Today's Date _______________________

Date of Accident:______________________________________ Time: ______________________

Were you: Driver_____ Passenger_____ Front Seat_____ Back Seat______

Were you wearing a seat belt? Yes No Shoulder Harness? Yes No

DESCRIPTION OF ACCIDENT

Were you struck: From Behind___ In front___ Right Front___ Right Middle___

Right Rear___ Left Front___ Left Middle___ Left Rear___

Were you: Moving____ Stopped____ Turning Right____ Turning Left___

Approximate speed of automobiles at time of impact:____________________________________

Did you see the accident coming? Yes No Direction you were looking at time of impact? __________________

Upon impact which way was your body thrown? Forward___ Backward___ Right___ Left___

Did you hit your head on anything? Yes No What? _______________________________

Did you lose consciousness? Yes No For how long? _______________________________

Amount of damage to vehicle? _________________________Type of vehicle________________________________

Was a police report filed? Yes No Citation issued? Yes No To whom?___________________________

When did the pain begin? ____

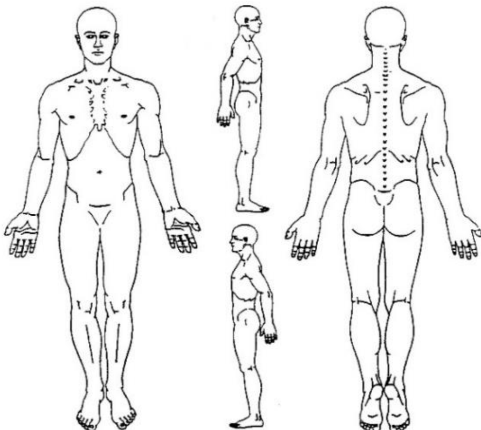
Since MVA pain is: Less____ Same ____ Worse____

Were you transported to hospital? Yes No Which hospital? ____________________________

Were x-rays taken? Yes No What x-rays? ____

Have you seen another Dr. since the MVA? No Yes Name:________________________________

What treatment did you receive? ____



Please indicate on the body where your pain is

On a scale from 0-10, with 10 being the worst pain, and 0 being no pain, what is your current rating of pain?

0 1 2 3 4 5 6 7 8 9 10