

If your injuries could be due to an auto accident, please fill out this page.

ACCIDENT PATIENT HISTORY

Place of Accident: _____

Date of Accident: _____ Time: _____

Were you: Driver Passenger Front Seat Back Seat

Were you wearing a seat belt? 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 impact: Yours _____ mph Other _____ mph

Did you see the accident coming? Yes No

Which way were you looking at impact? _____

Upon impact which way was your body thrown? Forward Backward Right Left

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

Lose consciousness? Yes No How Long? _____

Type of vehicle you were in _____ Amount of damage _____

Type of other vehicle _____ Amount of damage _____

Police report filed? Yes No

Citation Issued? Yes No To whom? _____

TREATMENT RECEIVED

When did the pain begin?

Since MVA – pain is: Less Same Worse

Transported to Hospital? Yes No

By Whom? Self Ambulance Air Ambulance

Which Hospital? _____

X-rays Taken? Yes No What X-rays? _____

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

Dr. Name _____ Where _____

What treatment did you receive? _____