AUTOMOBILE ACCIDENT HISTORY

AUTOMOBILE ACCIDENT:

Name _____ Sex _____ Age _____

Address _____ Drivers License # _____

GENERAL SYMPTOMS:

Did you hit any part of your body during the collision, for example, head on dash, chest on steering wheel?_____

If yes, which part and how?_____

Where were you taken after the accident? _____

Were you hospitalized? _____ If yes, for how long? _____

Did you receive care from any other health care specialist?_____

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? _____ If yes, how and when?_____

_____

ACCIDENT HISTORY:

Date Time _____

State How Accident Happened in your own words_____

_____

_____

_____

Were you driving? _____ Was it your car? _____ If not, who's? _____

Passenger? Front _____ Back_____ Right Side_____ Left Side_____

Were you rotated in seat?_____

Other People in car: Name and Address_____

Name and Address_____

Name and Address_____

Seat belts on?_____ Shoulder harness on?_____

Was it: Daylight?_____ Night_____Dusk_____ Dawn_____

Were you tired?_____Were you awake?_____

How long had you been in the car?_____

Where were you prior to the accident?_____

What were the weather conditions?_____

What were the traffic conditions?_____

What was the posted speed limit?_____How fast were you going?_____

Type of road: Two Lane_____ Four Lane_____ Gravel_____Tar_____

Did it happen at a stop sign?_____ Did it happen at a traffic light?_____ Did it happen at an intersection?_____

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