# AUTOMOBILE ACCIDENT HISTORY

Name: ______________________ Age: ________ Date of Birth: ________ ❑ M ❑ F

Address: ______________________

City: ______________________ State: ________ Zip: ________

SS#: ______________________ Driver's License #: ______________________

Insurance Company: ______________________ Name of Agent: ______________________

Address of Insurance Company: ______________________

Have you retained an attorney? ❑ Yes ❑ No Name and Address of Attorney: ______________________

______________________

## GENERAL SYMPTOMS:

Did you hit any part of your body during the collision, for example: head on dash, chest on steering wheel? ❑ Yes ❑ No

If yes, which part and how? ______________________

______________________

Where were you taken after the accident? ______________________

Were you hospitalized? ❑ Yes ❑ No If yes, for how long? ______________________

Did you receive care from any other health care specialist? ❑ Yes ❑ No 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? ❑ Yes ❑ No If yes, how and when? ______________________

______________________

## ACCIDENT HISTORY:

Date of Accident: ______________ Time of Accident: ________ ❑ A.M. ❑ P.M.

State how accident happened in you own words: ______________________

______________________

______________________

What type of vehicle were you in? Make: ______________ Year: ______________

Were you driving? ❑ Yes ❑ No Was it your car? ❑ Yes ❑ No If not, whose? ______________________

❑ Passenger? ❑ Front ❑ Back ❑ Right Side ❑ Left Side Were you rotated in seat? ❑ Yes ❑ No

Were you reclined? ❑ Yes ❑ No Other: ______________________

Other people in car? ❑ Yes ❑ No Names and Addresses: ______________________

______________________

Were they injured? ❑ Yes ❑ No If yes, explain: ______________________

______________________

(over)