History of Motor Vehicle Collision

Patient # _____

If you do not know an answer write "unsure". If you can only estimate an answer write "est." after your answer.

Date of collision: _____

Has your employment status changed since the time of the collision? ☐ no ☐ yes, why? _____

_____

Did you have any disabilities or work restrictions (self-imposed or physician ordered) before this collision? ☐ no ☐ yes,

Please describe _____

In the past, have you had any:

Worker's compensation claims? ☐ no ☐ yes; Motor vehicle collisions? ☐ no ☐ yes; Other personal injuries? ☐ no ☐ yes

Any other injuries to your head, neck, back or arms/legs from falls, sports, etc. ☐ no ☐ yes ***If yes to any of the above see below***

When?_____; Awards ordered? ☐ no ☐ yes; Permanent disability? ☐ no ☐ yes; Type of injury _____

Type of treatment: _____ Ongoing problems from it? _____

Type of vehicles, this collision:
- Your vehicle: year: _____ make: _____ model: _____
- Other vehicle: year: _____ make: _____ model: _____
- If a van or truck involved was it: ☐ empty or ☐ loaded?

Were you the: ☐ driver ☐ front seat passenger ☐ back driver seat ☐ back passenger seat ☐ _____

Road conditions: ☐ night ☐ day ☐ dusk ☐ foggy ☐ damp ☐ wet ☐ rainy ☐ snow ☐ ice ☐ _____

Was the car: ☐ stopped or ☐ moving, at what estimated speed? _____

Type of restraints: ☐ seat belt ☐ shoulder belt ☐ air bag equipped ☐ air bag deployed

Head rest: ☐ none ☐ non-adjustable ☐ adjustable, was head rest in a different position after collision? ☐ no ☐ yes ☐ unsure

Was your seat damaged after the impact? ☐ no ☐ yes, describe _____

Position of head at impact: ☐ neutral (looking forward) ☐ turned left ☐ turned right ☐ _____

Position of arms/hands at impact: _____

Were breaks applied? ☐ no ☐ yes, ☐ hard or ☐ lightly

Were you forewarned? (i.e. screeching tires, see approaching vehicle in rearview mirror) ☐ no ☐ yes, _____

What were your body movements during the impact? (i.e. Back then forward, etc..) _____

Did any part of your body or head strike the interior of the vehicle? ☐ no ☐ yes, describe _____

Were you wearing glasses or a hat ☐ no ☐ yes, where they still on your head following the impact? ☐ no ☐ yes.

Was there any loss of consciousness ☐ no ☐ yes, how long? _____. Any post-traumatic amnesia? ☐ no ☐ yes

Were there any immediate symptoms? ☐ no ☐ yes, what were they? _____

Were there any delayed symptoms? ☐ no ☐ yes, when did they start? _____

List delayed symptoms: _____

Where did you go immediately after the collision? ☐ hospital ☐ Dr's office ☐ home ☐ work ☐ _____

By: ☐ ambulance ☐ you drove ☐ you were driven ☐ _____

What was done: ☐ exam ☐ x-rays ☐ medicine ☐ referral to _____ ☐ other _____

List other treatments you have had (in order): _____

Was the vehicle drivable after the collision? ☐ no ☐ yes ☐ unsure. Was a police report made? ☐ no ☐ yes

Has there been an estimate concerning property damage to the vehicle? ☐ no ☐ yes, how much $_____

Were there other occupants in the vehicle? ☐ no ☐ yes, were they injured? ☐ no ☐ yes ☐ unsure

Guardian or **Patient's Signature** _____ D.C. Signature _____ Date _____

TURN PAGE OVER

Crash Diagram

Please draw a diagram of the roadway or streets where the crash occurred, indicating the vehicles involved and direction of travel using the following symbols:

→ = Direction

1 = Your Vehicle

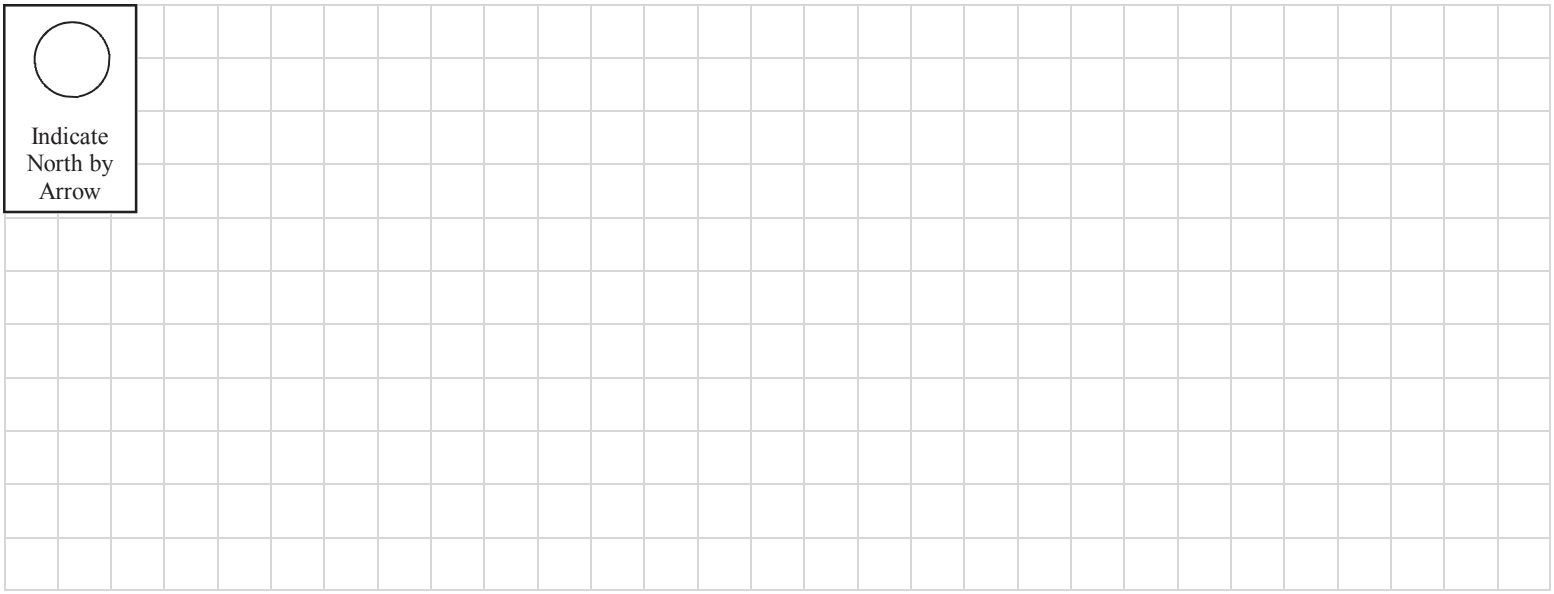
2 = Other Vehicle

= Pedestrian

= North

Select one of the following if the crash did not occur on a public way:

- ☐ Off-street parking lot
- ☐ Garage
- ☐ Mall/Shopping center
- ☐ Other private way



Description of What Happened

_____

_____

_____

_____

_____

_____

_____

_____

Guardian or **Patient's Signature** _____ D.C. Signature _____ Date _____