

HISTORY OF MOTOR VEHICLE INJURY

- 1.) What was the date and time of your injury? Date _____ Time _____ a.m. p.m.
- 2.) What type of motor vehicle injury was this?: Auto vs. Auto Auto vs. Pedestrian Auto vs. Bicycle
 Auto vs. Motorcycle Other: _____
- 3.) Were you: the driver a passenger **Were other people in the vehicle with you?:** Yes No
- 4.) Type of vehicle that you were in: Year _____, if unknown, was the vehicle: newer or older
Make of Vehicle _____, if unknown, was the vehicle: compact vehicle mid-size vehicle
 large vehicle pick-up commercial truck bicycle motorcycle pedestrian other: _____
- 5.) Describe: Your vehicle was struck by another vehicle Your vehicle struck another vehicle
- 6.) Type of other vehicle involved in accident: Year _____, if unknown, was the vehicle: newer or older
Make of Vehicle _____, if unknown, was the vehicle: compact vehicle mid-size vehicle
 large vehicle pick-up commercial truck bicycle motorcycle pedestrian other: _____
- 7.) Was the impact to your vehicle: head-on on the left on the right from the rear other: _____
- 8.) Would you describe the force of the collision as: major moderate other: _____
- 9.) Describe in detail, how the accident occurred: _____

- 10.) Were you wearing your seat belt? Yes No **With shoulder restraint?** Yes No
- 11.) If you were the driver, did you have your foot on the brake prior to impact? Yes No
- 12.) Were you aware the collision was about to take place prior to impact? Yes No
- 13.) Just prior to impact: Did you have time to brace yourself? Yes No
- 14.) Were you looking: straight ahead in the rearview mirror to the left to the right don't remember
- 15.) Did your head strike anything inside your vehicle? Yes No If yes, describe: _____
- 16.) Were you knocked unconscious? Yes No If yes, for how long? _____
- 17.) What were the road conditions? Dry Wet Icy Other: _____
- 18.) How long after the collision did you begin to experience symptoms? Immediately Within a few minutes
 within a few hours that same evening within a few days other: _____
- 19.) Did you receive treatment from any other physicians before coming to our office? Yes No
If yes, from whom? _____
- 20.) What type of treatment did you receive? _____
- 21.) Was/Did the treatment: successful unsuccessful gave temporary relief reduced the intensity of the pain
 did not alleviate the pain other: _____
- 22.) Are you presently taking any medications? Yes No **If yes, please list them:** _____

- 23.) Has this injury caused you any loss or alteration of your normal work or leisure activities? Yes No
If yes, please describe: _____

Are you Represented by an attorney?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please list:	Attorney name _____ Street Address _____ City _____ State _____ Zip _____ Phone _____ Fax _____
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Patient Signature _____

Date _____