SUPPLEMENTAL HISTORY: AUTO ACCIDENT

Name _____ Today's Date _____ Time _____ ☐ am ☐ pm

Date of accident _____ Time of accident _____ ☐ am ☐ pm

Were you the: ☐ Driver ☐ Passenger in front seat ☐ Passenger in back seat

Were you wearing a seat belt? ☐ Yes ☐ No

How many vehicles were involved in the accident? ☐ One ☐ Two ☐ Three ☐ Four ☐ Other _____

How many people were in your vehicle? ☐ One ☐ Two ☐ Three ☐ Four ☐ Other _____

Make and model of your vehicle _____

Make and model of the other vehicle _____

What direction were you headed? ☐ North ☐ South ☐ East ☐ West

On what street? _____ In what city? _____ In what county? _____ In what state? _____

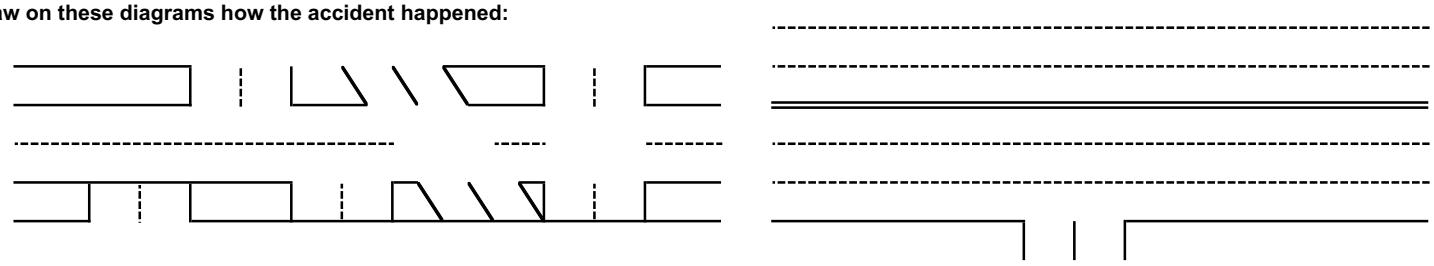
Type of accident: ☐ I was hit ☐ I hit someone else ☐ Rear-ended ☐ Broadside ☐ Head-on ☐ Other _____

Speed: Was your vehicle: ☐ Stopped ☐ Braking ☐ Moving _____ mph (Approximately) ☐ Forward ☐ Backward

Speed: Was the other vehicle: ☐ Stopped ☐ Braking ☐ Moving _____ mph (Approximately) ☐ Forward ☐ Backward

Visibility at the time of the accident: ☐ Good ☐ Poor ☐ Fair

Draw on these diagrams how the accident happened:



Describe the accident in your own words: _____

_____

_____

_____

Approximate damage done to the car you were in (dollar amount) $_____ ☐ Damage estimate from body shop not completed yet

Were you aware the accident was going to happen before impact? ☐ Yes ☐ No

Did you brace yourself before impact? ☐ Yes ☐ No

Head position at the time of impact? ☐ Turned ☐ Right ☐ Left ☐ Straight ahead ☐ Looking back

Body position at the time of impact? ☐ Turned ☐ Right ☐ Left ☐ Straight ahead

Can you recall what parts of your head or body hit what parts of your car during the accident? _____

_____

Could you move all your body parts after the accident? ☐ Yes ☐ No If no, explain: _____

_____

As a result of the accident were you: ☐ Shaky / upset ☐ Disoriented / confused ☐ Rendered unconscious

Have you suffered from memory loss since the accident? ☐ Yes ☐ No If yes, describe: _____

_____

Were you hospitalized? ☐ Yes ☐ No If yes, hospital _____

Have you been treated by a physician? ☐ Yes ☐ No If yes, name _____

What type of treatment? _____ How often? _____ Results _____

Are you still being treated? ☐ Yes ☐ No

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Describe how you felt:

During the accident _____

Immediately after the accident _____

Later that day _____

The next day _____

Please check your current symptoms:

☐ Jaw / TMJ pain (R / L)	☐ Arm tingling / numbness (R / L)	☐ Radiating pain to hip / leg (R / L)	☐ Muscle spasms / soreness
☐ Headache (R / L)	☐ Elbow pain (R / L)	☐ Hip / leg pain (R / L)	☐ Anxiety / depression
☐ Neck pain (R / L)	☐ Wrist pain (R / L)	☐ Leg tingling / numbness (R / L)	☐ Dizziness / fainting
☐ Mid back pain (R / L)	☐ Hand pain (R / L)	☐ Knee pain (R / L)	☐ Fatigue
☐ Radiating pain to head (R / L)	☐ Hand tingling / numbness (R / L)	☐ Ankle pain (R / L)	☐ Ringing / buzzing in the ears
☐ Radiating pain to shoulder / arm (R / L)	☐ Low back pain (R / L)	☐ Foot pain (R / L)	☐ Visual disturbances
☐ Shoulder / arm pain (R / L)	☐ Sacroiliac pain (R / L)	☐ Foot tingling / numbness (R / L)	☐ Other _____

List any other present complaints and symptoms _____

_____

Before the accident did you have any of your present complaints? ☐ Yes ☐ No

If yes, describe _____

Have you lost time from work as a result of this accident? ☐ Yes ☐ No

If yes, list dates lost _____ Type of employment _____

Insurance companies involved:

Insurance company of party responsible for payment _____

Claim # _____ Phone _____ Adjustor _____

Your automobile insurance company _____

Agent _____ Phone _____ Do you have Med-Pay coverage? ☐ Yes ☐ No ☐ I'm not sure

Your group health insurance company _____

Policy # _____ Phone _____

Have you retained an attorney? ☐ Yes ☐ No

If yes, who? _____ Phone _____

Assignment Of Benefits

By signing this form you authorize your insurance company to make payments directly to this clinic; however, you are ultimately responsible for payment. If your insurance company sends checks to you, you are legally obligated to bring them to us.

_____ _____

Signature of patient or legal guardian **Date**

_____

Clinic Representative