HISTORY OF COLLISION

NAME_____ DATE_____

TYPE OF ACCIDENT: MOTOR VEHICLE_____ WORK-RELATED_____ SLIP&FALL_____
OTHER _____

Date of accident _____ Time of day _____ AM / PM
Place of accident_____ # of cars involved? _____

Road conditions: dry/wet/icy/snow packed/ construction/ gravel packed.

Year & make of car you were in _____ Were you: Driver / Passenger? (other passengers?)
Automatic / Manual transmission Where seated, if passenger? _____
Estimated speed of your vehicle _____ Estimated speed of other vehicle _____

What part of your car was hit? Rear-ended / head-on / Broadsided (passenger / Driver) / Rollover / Flipped over
Please describe the incident _____
_____
_____

How were you seated? (slumping, etc) _____ One / two hands on the steering wheel?
Foot on the brake / gas pedal / clutch? Left/Right Automatic cruise control? Yes / No
Position of head restraint _____ Did air bag deploy? Yes / No
Were you wearing a seatbelt / shoulder harness? Yes / No Chemical burns? Yes / No
Looking straight ahead / down/ up at rearview mirror/ to the side (Left / Right)

Upon impact my _____ (body part) struck the windshield / door/ dashboard / steering wheel / other __
_____
I received: cuts/ bruises/ scrapes _____
Upon impact my vehicle: _____

Make of the other vehicle _____ Make of additional (3rd) vehicle _____
Estimated damage to your vehicle _____ Estimated damage, other vehicle _____

Were you aware of oncoming collision? Yes/ No Did you lose consciousness? Yes / No
What did you do? Braced / ducked down / Put out arm to assist passenger / Other _____

Did police come to the scene? Yes/ No Did paramedics treat you / other passenger? Yes / No
Was there anyone else injured? Yes / No How many injured persons? _____
Who was cited? _____ Was a report filed? Yes / No
Have you notified your Insurance Co? Yes / No Do you have an attorney? Yes / No _____
Your Insurance:_____ Other Party Insurance: _____

Did you go to the hospital? Yes / No Ambulance? Yes / No Name of Hospital _____
What was done at the hospital? X-rays/CT/MRI Medication/ Brace (neck/back/other_____/ Stitches/ Surgery/_____

When did your symptoms start? _____ Did you have symptoms prior to the MVA? Yes / No___
What treatments have you had? _____ Where? _____ When? _____

Have you missed work? Yes / No _____ Occupation _____
Are you still disabled? Yes / No _____ Need for household services? Yes / No _____

Any previous accidents? Yes / No Were you Injured? Yes / No
Dates(s)_____ Type of Injury: _____

Any previous surgeries? Yes / No _____ Hospitalizations? Yes / No _____
Broken bones / Fractures? Yes / No _____

NAME _____ DATE _____

Since this accident have you had any of the following symptoms? (Please circle)

Side of head/ Back of head/ Forehead/ Face pain (circle)		
Headaches: aching/ dull/ sharp/ stabbing/ throbbing		
Head seems too heavy.		
Jaw pain	R	L
Neck pain		
Neck stiffness		
Pain radiating to shoulder	R	L
Shoulder pain	R	L
Shoulder stiffness	R	L
Arm pain	R	L
Pins & Needles in arm	R	L
Elbow pain	R	L
Forearm pain	R	L
Cold hands	R	L
Wrist pain	R	L
Hand pain	R	L
Finger pain	R	L
Numbness in fingers	R	L
Chest pain		
Rib pain	R	L
Shortness of Breath		
Upper back pain		
Middle back pain		
Lower back pain		
Lower back stiffness		
Abdominal pain		
Hip/ Groin/ Thigh pain (circle)	R	L
Pain radiating into legs	R	L
Pins & needles in legs	R	L
Knee pain	R	L
Lower leg/ Calf/ Shin pain	R	L
Ankle pain	R	L
Foot pain	R	L
Toe pain	R	L
Numbness in toes	R	L
Cold feet	R	L

Tinnitus (ringing in ears)
Buzzing in ears
Phonophobia (sensitivity to sound)
Photophobia (sensitivity to light)
Blurring of vision
Dizziness
Lightheadedness
Fainting
Loss of balance
Sleeping difficulty
Fatigue
Stress
Nervousness
Boredom
Irritability
Tension
Anxiety
Outbursts of anger
Mood swings
Personality changes
Nightmares
Fear of travel in a car
Flashbacks
Depression
Loss of memory
Loss of appetite
Loss of taste
Loss of smell
Loss of libido (don't enjoy sex)
Face flushed
Fever
Cold sweats
Stomach upset
Indigestion
Diarrhea
Constipation
Concentration problems
Confusion
Easily distracted
Apathy
Arithmetic problems
Can't plan or carry out plans
Alcohol intolerance
Difficulty with new or abstract concepts