Optimal Health Center
Live Better, Choose Wellness

Automobile Accident History Form

Patient Name: _____ **Birth Date:** _____

Address,City,State,Zip: _____

Home Phone: _____ **Cell Phone:** _____ **Email:** _____

Occupation: _____ **Employer:** _____

Spouse's Name: _____ **Business/Employer:** _____ **Spouse Phone:** _____

Who is your primary care physician? _____ **Phone:** _____

Address: _____ **Date of last physical/exam?** _____

Date of Accident: _____ **Time of Accident:** _____ **am / pm** □ **Daylight** □ **Dawn** □ **Dusk** □ **Dark**

Road conditions at the time of the accident: _____ □ **Wet** □ **Dry** □ **Snow** □ **Ice** □ **Other** _____

Was the accident on the job? ☐ **Yes** ☐ **No** **Were you in a company vehicle?** ☐ **Yes** ☐ **No**

Where were you seated in the vehicle? _____ □ **Driver** □ **Passenger** □ **Rear-seat** □ **Other** _____

Were you aware of the approaching collision prior to impact, or did it catch you by surprise? ☐ **Aware** ☐ **Surprise**

Did you lose consciousness upon impact? ☐ **Yes** ☐ **No**

Did you experience a flash of light or explosion in your head? ☐ **Yes** ☐ **No**

Did the police come to the accident scene? ☐ **Yes** ☐ **No** **Is there a police report?** ☐ **Yes** ☐ **No**

If yes, please provide us with a copy at your earliest convenience.

Did you go to the hospital? ☐ **Yes** ☐ **No** **When?** □ **Immediately** □ ____**hours later** □ ____**days later**

Which hospital? _____

How did you get to the hospital? _____ **How long did you stay in the hospital?** _____

What did the hospital do for your injuries? (collars, splints, x-rays, medication etc.) _____

What area were x-rays? _____

What was their diagnosis? _____

What did they recommend for follow-up care? _____

Was any other doctor consulted after your accident? ☐ **Yes** ☐ **No**

If yes, please complete information below.

Dr. _____ **Specialty?** _____ **Date first seen:** _____

Type of treatment: _____ **Treatment frequency:**_____ **How long did you treat?** _____

Dr. _____ **Specialty?** _____ **Date first seen:** _____

Type of treatment: _____ **Treatment frequency:**_____ **How long did you treat?** _____

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Were you wearing a seatbelt? ☐ Yes ☐ No

If yes, did you receive any injury or bruise from the seatbelt? ☐ Yes ☐ No

Did you head hit the headrest during the accident? ☐ Yes ☐ No

If adjustable, was the position of the headrest altered? ☐ Yes ☐ No

Was the seat adjustment altered by the accident? ☐ Yes ☐ No

Was the seat broken by the accident? ☐ Yes ☐ No

Did the air-bag deploy? ☐ Yes ☐ No If yes, did it strike you? ☐ Yes ☐ No

If yes, where? _____

Which way was your head pointing at the point of impact? ☐ Straight ☐ Right ☐ Left Body? ☐ Straight ☐ Right ☐ Left

Where were your hands? ☐ One on the wheel ☐ Both on the wheel ☐ Not applicable

Were you wearing a hat or glasses at the time of impact? ☐ Yes ☐ No

If so, were they still on after the accident? ☐ Yes ☐ No

At the time of the accident, did you become or experience any of the following:

☐ Confused ☐ Disoriented ☐ Light headed ☐ Dizzy ☐ Nauseated

☐ Blurred Vision ☐ Ringing/Buzzing in Ears ☐ Loss of balance ☐ Other: _____

Do you still have any of those symptoms? ☐ Yes ☐ No If yes, which ones? _____

Check symptoms you have noticed since the accident:

☐ Headaches/Migraines	☐ Neck Pain	☐ Upper Back pain	☐ Shoulder Pain	☐ Midback Pain
☐ Low Back Pain	☐ Depression	☐ Buzzing in Ears	☐ Arm/Leg Pain	☐ Jaw Pain/Clicking
☐ Dizziness	☐ Fatigue	☐ Loss of Memory	☐ Cold Hands/Feet	☐ Numbness/Tingling
☐ Loss of Smell	☐ Irritability	☐ Digestive Problems	☐ Joint Pain/Stiffness	☐ Menstrual Problems
☐ Pinched Nerve	☐ Loss of Sleep	☐ Loss of Balance	☐ Chest Pain	☐ Light Bothers Eyes
☐ Fever	☐ Nervousness	☐ Vision Problems	☐ Urinary Problems	☐ Sleeping Problems
☐ Paralysis	☐ Tension	☐ Fainting	☐ Pins/Needles Feeling	☐ Stomach Upset
☐ Difficulty Swallowing	☐ Sciatica	☐ Sinus Pain	☐ Sore Muscles	☐ Head Feel too Heavy
☐ Other				

Please describe, to the best of your knowledge, what happened during this accident.

_____

_____

_____

_____

_____

_____

You may draw the accident here.

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YOUR CAR

List the year, make and model of the car you were in: YEAR:_____MAKE:_____MODEL:_____

Was your car stopped at the time of impact? ☐Yes ☐No If yes, was the driver's foot on the brake? ☐Yes ☐ No
If no, estimate the speed of the vehicle you were in: _____Mph

If your vehicle was moving at the time of impact, was it: ☐ Slowing down ☐ Gaining speed ☐ Steady speed

THE OTHER CAR

List the year, make and model of the other car: YEAR:_____MAKE:_____MODEL:_____

Was the other car moving at the time of impact? ☐Yes ☐No

If yes, what was the approximate speed of the vehicle?_____Mph

At the time of impact, was the other car: ☐ Slowing down ☐ Gaining speed ☐ Steady speed

AUTOMOBILE INSURANCE INFORMATION

Driver of the automobile you were in:_____Name of their auto insurance:_____

Policy #:_____Claim #:_____

Auto insurance phone #:_____Name of insurance adjuster:_____

Driver of the other vehicle:_____Name of their auto insurance:_____

Policy #:_____Claim #:_____

Auto insurance phone #:_____Name of insurance adjuster:_____

CURRENT COMPLAINTS – List current symptoms separately in order of severity

1st Body Part:_____

Date symptom first appeared:_____

How often do you experience these symptoms? Constant 100%

Frequent 75% Intermittent 50% Occasional 25% Rare 10%

What makes symptoms increase?_____

What makes symptoms decrease?_____

Type of pain? Sharp Dull Aching Burn Throb Numb

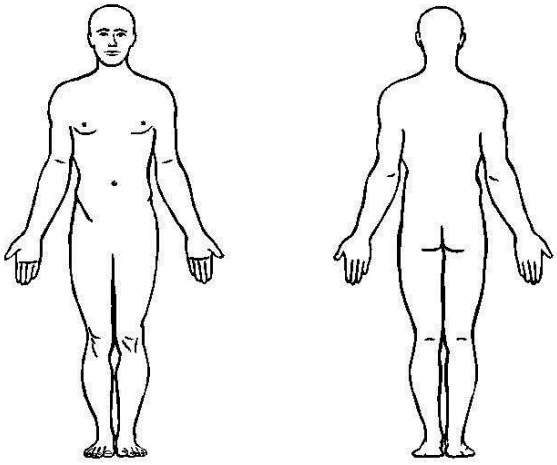
Other:_____

Please rate the intensity of your symptoms (0 being no symptoms,

10 being extreme symptoms): _____

Where does the pain radiate?_____

Please mark areas of pain on the figures below.



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CURRENT COMPLAINTS – List current symptoms separately in order of severity.

2nd Body Part:_____

Date symptom first appeared:_____

How often do you experience these symptoms? Constant 100%

Frequent 75% Intermittent 50% Occasional 25% Rare 10%

What makes symptoms increase?_____

What makes symptoms decrease?_____

Type of pain? Sharp Dull Aching Burn Throb Numb

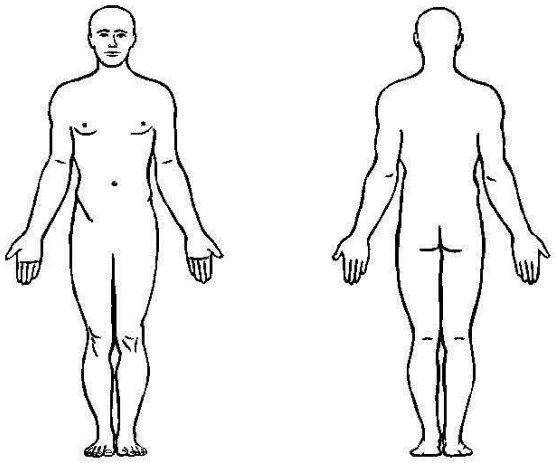
Other:_____

Please rate the intensity of your symptoms (0 being no symptoms,

10 being extreme symptoms): _____

Where does the pain radiate?_____

Please mark areas of pain on the figures below.



3rd Body Part:_____

Date symptom first appeared:_____

How often do you experience these symptoms? Constant 100%

Frequent 75% Intermittent 50% Occasional 25% Rare 10%

What makes symptoms increase?_____

What makes symptoms decrease?_____

Type of pain? Sharp Dull Aching Burn Throb Numb

Other:_____

Please rate the intensity of your symptoms (0 being no symptoms,

10 being extreme symptoms): _____

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