

PERSONAL INJURY - AUTO/CYCLE ACCIDENT HISTORY

Skip to the next section if your injury is not auto-related

What type of accident caused your injury? Two or more automobiles
 Injured by a vehicle as a pedestrian
 Motorcycle/bicycle and no vehicle
 An automobile and a motorcycle/bicycle Other

When did the accident occur? ____ / ____ / _____

Where in the vehicle were you at the time of the accident? _____

(If pedestrian) What were you doing at the time of the accident? _____

In what direction were you looking at the time of impact? _____

What is the size/type of your vehicle? _____

Were you wearing a seatbelt? Yes No

(If cycle) What type of protection did you have? _____

Did the airbag deploy? Yes No

Did you come in contact with anything at the time of collision? (Explain) Yes No

What was the position of the headrest (in relation to your head)? _____

Did you receive an injury to the head? Yes No

Did you lose consciousness? Yes No

Did police arrive at the scene Yes No

Was an accident report taken? Yes No

Which part of your vehicle or cycle was impacted? Choose all that apply. Front right Front left Front head on
 Rear end - center Rear right Rear left
 Left side (driver's side) Right side (passenger's side)
 Unknown

What type of protection did you have? _____

In what direction was your vehicle/cycle moving?

What was the estimated speed of your vehicle/cycle?

What was the extent of the damage to your vehicle?

What was the extent of the damage to the other vehicle/cycle?

In what direction was the other vehicle/cycle moving?

What was the estimated speed of the other vehicle/cycle?

Was your vehicle/cycle towed from the scene? Yes No

Did Emergency Medical Services arrive at the scene? Yes No

How did you leave the scene of the accident?

Where was discomfort felt immediately following the accident?

Describe your discomfort after the accident.

What treatment, if any, have you received since the accident?

Are there any additional symptoms which have appeared since the accident occurred? (Explain) Yes No

How have your symptoms changed since the accident? Worsened Remained the same Improved

PERSONAL INJURY - NON-AUTO ACCIDENT HISTORY

What type of accident caused your injury?

Work injury (not auto related)

Slip and fall (away from home)

Home injury Sports injury Other

What is the date of your scheduled appointment?

____ / ____ / _____

When did the accident occur?

____ / ____ / _____

What were you doing at the time of the accident?

In what direction were you looking at the time of impact? (if applicable)

Did you receive an injury to the head? Yes No

Did you lose consciousness? Yes No

Did police arrive at the scene Yes No

Was an accident report taken? Yes No

Did Emergency Medical Services arrive at the scene? Yes No

How did you leave the scene of the accident?

Where was discomfort felt immediately following the accident?

Describe your discomfort after the accident.

What treatment, if any, have you received since the accident?

Are there any additional symptoms which have appeared since the accident occurred? (Explain)

Yes No

How have your symptoms changed since the accident?

Worsened Remained the same Improved
