

## 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?**

\_\_\_\_\_

**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

**What type of protection did you have?**

\_\_\_\_\_

**Did the airbag deploy?**

- ☐ Yes ☐ No

**Did you come in contact with anything at the time of the collision?**

☐ 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 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 or cycle moving?** \_\_\_\_\_

**What was the estimated speed of your vehicle or cycle?** \_\_\_\_\_

**What was the extent of the damage to your vehicle?** \_\_\_\_\_

**What was the extent of the damage to the other vehicle or cycle?** \_\_\_\_\_

**In what direction was the other vehicle or cycle moving?** \_\_\_\_\_

**What was the estimated speed of the other vehicle or cycle?** \_\_\_\_\_

**Was your vehicle or 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?** ☐ 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 (but 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?

\_\_\_\_\_

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?

☐ Yes ☐ No

\_\_\_\_\_

How have your symptoms changed since the accident?

☐ Worsened ☐ Remained the same ☐ Improved

\_\_\_\_\_