

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
