

## 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?**

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

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

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

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

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

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**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?**

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**Where was discomfort felt immediately following the accident?**

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**Describe your discomfort after the accident.**

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

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**Are there any additional symptoms which have appeared since the accident occurred?**

Yes  No

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**How have your symptoms changed since the accident?**

Worsened  Remained the same  Improved

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## 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

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