



# Motor Vehicle Crash History

Please Print

Date: \_\_\_\_\_

\*Please provide staff with copies of all police reports, and insurance information (Covered Selections Page on Auto Policy and Health Insurance Card)\*

Dr.  Mr.  Mrs.  Ms.  Miss Marital status:  M  S  W  D

Last Name First Name Middle Initial Nick Name

Address City State Zip Code

Home phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Email address: \_\_\_\_\_

Social Security No.: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex:  M  F

Occupation (specific job title): \_\_\_\_\_ Employer: \_\_\_\_\_

Work Address: \_\_\_\_\_

Person to contact in an emergency: \_\_\_\_\_ Phone: \_\_\_\_\_

## Responsible Party

Name of person responsible for payment of this account: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Phone: \_\_\_\_\_

Address City State Zip Code

## Crash/Injury History

1. Date of Crash: \_\_\_\_\_ Time of Day: \_\_\_\_\_ Road Condition:  Dry  Wet

2. Were you:  Driver  Passenger  Front Seat  Back Seat

3. Number of people in your vehicle? \_\_\_\_\_

4. Were you wearing a seat belt?  Y  N (If no, Skip the next question)

5. If yes, were you wearing a lap belt?  Y  N Lap belt and shoulder harness?  Y  N

6. What direction were you headed?  North  South  East  West

*If you are not sure, leave direction questions blank.*

On (name of street and city): \_\_\_\_\_

7. What direction was the other vehicle headed?  North  South  East  West

On (name of street and city): \_\_\_\_\_

8. Were you struck from:  Behind  Front  Left Side  Right Side

Other combination, please describe: \_\_\_\_\_

9. What was the position of your head during the crash?

Straight Ahead  Turned Right  Turned Left  Other \_\_\_\_\_

10. Did any part of your body strike/hit anything inside of your vehicle (steering wheel, dashboard,etc)?  Y  N

If yes, please explain: \_\_\_\_\_

11. Did any items become displaced in the vehicle (rearview mirror, ashtray, packages, etc.)?  **Y**  **N**

If yes, please describe: \_\_\_\_\_

12. If your vehicle was equipped with air bags, did they activate?  **Y**  **N**

13. Make/model of your car: \_\_\_\_\_ Make/model of other vehicle: \_\_\_\_\_

14. Were the police notified?  **Y**  **N** Please provide this office with a copy of the police report.

15. In your own words, please describe the accident: \_\_\_\_\_  
\_\_\_\_\_

16. Did you have any physical complaints BEFORE the accident?  **Y**  **N**

If yes, please describe in detail: \_\_\_\_\_

17. Please describe how you felt:

a. DURING the accident: \_\_\_\_\_

b. IMMEDIATELY AFTER the accident: \_\_\_\_\_

c. LATER THAT DAY: \_\_\_\_\_

d. THE NEXT DAY: \_\_\_\_\_

18. Did you lose consciousness during the crash?  **Y**  **N** If yes, for how long? \_\_\_\_\_

19. Where were you taken after the accident? \_\_\_\_\_

20. Have you been treated by another doctor since this accident?  **Y**  **N**

If yes, please list the doctor's name and address: \_\_\_\_\_

What type of treatment did you receive? \_\_\_\_\_

21. Did this accident occur while you were performing your regular job duties?  **Y**  **N**

22. What is your **number-one** problem or the **one area** of greatest pain? \_\_\_\_\_

23. Please rate the level of this pain on the following scale: 0 is no pain, 10 is severe pain or the worst pain you have ever felt. If your pain varies from day to day please circle two numbers to indicate a range of your pain. 0 1 2 3 4 5 6 7 8 9 10

24. Since this injury occurred, is your pain:  Improving  Getting Worse  Staying the Same

25. How often do you experience the pain?

1-2 hours per day  About half of the day  Most of the day  The pain never goes away

26. How does the pain effect your daily activities?

It does not affect my daily activities  I have had to change how I do things

I have had to stop doing some of my daily activities  I am unable to perform daily activities

27. What **increases** your pain? \_\_\_\_\_

28. What **decreases** your pain? \_\_\_\_\_

29. Have you ever experienced this problem before?  **Y**  **N** When? \_\_\_\_\_

30. Do you have a previous illness/disease which affects your present condition?  **Y**  **N**

If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

31. List any other complaints currently bothering you and rate your pain level for each.

- a. \_\_\_\_\_ 0 1 2 3 4 5 6 7 8 9 10
- b. \_\_\_\_\_ 0 1 2 3 4 5 6 7 8 9 10
- c. \_\_\_\_\_ 0 1 2 3 4 5 6 7 8 9 10
- d. \_\_\_\_\_ 0 1 2 3 4 5 6 7 8 9 10

32. Have you lost time from work as a result of this accident?  Y  N

- a. Type of employment: \_\_\_\_\_
- b. Last day worked: \_\_\_\_\_

33. Have you ever been involved in an automobile accident before?  Y  N When? \_\_\_\_\_  
Were you injured?  Y  N Please explain: \_\_\_\_\_

34. List all medication you are currently taking (prescribed and over the counter) \_\_\_\_\_  
\_\_\_\_\_

35. List all surgeries you have had (with date) \_\_\_\_\_  
\_\_\_\_\_

If you have experienced any of the following conditions in the past mark a "P" on the line provided. If you are currently experiencing any of the following conditions please mark a "C" on the line provided. (check all that apply)

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> heart attack                    | <input type="checkbox"/> stroke                      | <input type="checkbox"/> arthritis                  | <input type="checkbox"/> gall bladder trouble      |
| <input type="checkbox"/> diabetes                        | <input type="checkbox"/> glaucoma                    | <input type="checkbox"/> fainting spells            | <input type="checkbox"/> kidney stones             |
| <input type="checkbox"/> bloody stools                   | <input type="checkbox"/> cancer                      | <input type="checkbox"/> asthma                     | <input type="checkbox"/> difficulty with urination |
| <input type="checkbox"/> prostate trouble                | <input type="checkbox"/> anemia                      | <input type="checkbox"/> AIDS                       | <input type="checkbox"/> ulcers                    |
| <input type="checkbox"/> diverticulitis                  | <input type="checkbox"/> dizziness                   | <input type="checkbox"/> chest pain                 | <input type="checkbox"/> menstrual cramping        |
| <input type="checkbox"/> loss of memory                  | <input type="checkbox"/> constipation                | <input type="checkbox"/> diarrhea                   | <input type="checkbox"/> shortness of breath       |
| <input type="checkbox"/> general fatigue                 | <input type="checkbox"/> nausea                      | <input type="checkbox"/> muscle cramping            | <input type="checkbox"/> sudden weight loss        |
| <input type="checkbox"/> ears ringing                    | <input type="checkbox"/> headache                    | <input type="checkbox"/> soreness in joints         | <input type="checkbox"/> loss of hearing           |
| <input type="checkbox"/> migraine                        | <input type="checkbox"/> epilepsy                    | <input type="checkbox"/> gout                       | <input type="checkbox"/> tuberculosis              |
| <input type="checkbox"/> syphilis                        | <input type="checkbox"/> knee/hip replacement        | <input type="checkbox"/> sprained ankle [ ] R [ ] L |  |
| <input type="checkbox"/> difficulty with bowel movements | <input type="checkbox"/> broken bones(specify) _____ |   |  |

**General Activities** (check all that apply)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> sleep on waterbed | <input type="checkbox"/> read in bed            | <input type="checkbox"/> fall asleep in recliner/on couch  |
| <input type="checkbox"/> sleep on stomach  | <input type="checkbox"/> needlepoint/knitting   | <input type="checkbox"/> use two or more pillows to sleep  |
| <input type="checkbox"/> sewing            | <input type="checkbox"/> lift weights.wt. mach. | <input type="checkbox"/> play video games(__hrs per week)  |
| <input type="checkbox"/> jog___x/wK        | <input type="checkbox"/> swim                   | <input type="checkbox"/> computer use (__hrs per week)     |
| <input type="checkbox"/> exercise___x/wk   | <input type="checkbox"/> use treadmill          | <input type="checkbox"/> watch Television (__hrs per week) |

Please add anything else you would like the doctor to know: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

