HISTORY OF MOTOR VEHICLE INJURY

1.) What was the date and time of your injury? Date _____ Time _____ □ a.m. □ p.m.

2.) What type of motor vehicle injury was this?: □ Auto vs. Auto □ Auto vs. Pedestrian □ Auto vs. Bicycle □ Auto vs. Motorcycle □ Other: _____

3.) Were you: □ the driver □ a passenger **Were other people in the vehicle with you?:** □ Yes □ No

4.) Type of vehicle that you were in: Year ____, **if unknown, was the vehicle:** □ newer or □ older
Make of Vehicle _____, **if unknown, was the vehicle:** □ compact vehicle □ mid-size vehicle □ large vehicle □ pick-up □ commercial truck □ bicycle □ motorcycle □ pedestrian □ other: _____

5.) Describe: □ Your vehicle was struck by another vehicle □ Your vehicle struck another vehicle

6.) Type of other vehicle involved in accident: Year ____, **if unknown, was the vehicle:** □ newer or □ older
Make of Vehicle _____, **if unknown, was the vehicle:** □ compact vehicle □ mid-size vehicle □ large vehicle □ pick-up □ commercial truck □ bicycle □ motorcycle □ pedestrian □ other: _____

7.) Was the impact to your vehicle: □ Head-on □ On the left □ On the right □ From the rear

8.) Would you describe the force of the collision as: □ major □ moderate □ other: _____

9.) Describe in detail, how the accident occurred: _____

_____

_____

10.) Were you wearing your seat belt? □ **Yes** □ **No** **With shoulder restraint?** □ Yes □ No

11.) If you were the driver, did you have your foot on the brake prior to impact? □ Yes □ No

12.) Were you aware the collision was about to take place prior to impact? □ Yes □ No

13.) Just prior to impact: Did you have time to brace yourself? □ Yes □ No

14.) Were you looking: □ Straight ahead □ In the rearview mirror □ To the left □ To the right □ Don't remember

15.) Did your head strike anything inside your vehicle? □ Yes □ No **If yes, describe:** _____

16.) Were you knocked unconscious? □ Yes □ No If yes, for how long? _____

17.) What were the road conditions? □ Dry □ Wet □ Icy □ Other: _____

18.) How long after the collision did you begin to experience symptoms? □ Immediately □ Within a few minutes □ Within a few hours □ That same evening □ Within a few days □ Other: _____

19.) Did you receive treatment from any other physicians before coming to our office? □ Yes □ No
If yes, from whom? _____

20.) What type of treatment did you receive? _____

21.) Was/Did the treatment: □ Successful □ Unsuccessful □ Gave temporary relief □ Reduced the intensity of the pain □ Did not alleviate the pain □ Other: _____

22.) Are you presently taking any medications? □ Yes □ No **If yes, please list them:** _____

_____

23.) Has this injury caused you any loss or alteration of your normal work or leisure activities? □ Yes □ No
If yes, please describe: _____

_____

_____

_____

Are you Represented by an attorney?	☐ Yes ☐ No	**If yes, please list:**	**Attorney name** _____ **Street Address** _____ **City** _____ **State** ____ **Zip** _____ **Phone** _____ **Fax** _____

Patient Signature _____ Date _____