Physio Health Clinic™

Auto Accident History

Name: _____ Todays Date(___/___/_____) Date of Accident(___/___/_____

INFORMATION ABOUT THE MOTOR VEHICLE ACCIDENT:

City where accident occurred_____ Were you the: ( )DRIVER ( )PASSENGER ( )PEDESTRIAN

Were you struck from: ( )FRONT ( ) REAR ( )LEFT SIDE ( )RIGHT SIDE
Were you aware of the collision prior to impact or did it catch you by surprise? ( )AWARE ( )UNAWARE
What position was your head facing during impact? ( )FORWARD ( )LEFT ( )RIGHT ( )OTHER____
Were you wearing a seatbelt with a shoulder harness? ( )YES ( )NO ( )LAP BELT ONLY ( )UNKNOWN
Head Restraint: ( )NONE ( )ADJUSTIBLE ( )UP ( )DOWN ( )SEATBACK ONLY ( )DON'T KNOW
Did Airbags Deploy? ( )YES ( )NO If YES, were you struck by Airbags? ( )YES ( )NO
Road conditions were: ( ) DRY ( )WET ( )ICY ( )SNOW Did the police show up to the scene? ( )YES ( )NO
Who was at fault? ( )Driver of other vehicle ( )Driver of my vehicle ( )Myself ( )Don't Know
Please describe the accident (i.e., Rear-ended, Side-swiped, Head-on etc.) _____

_____

_____

Did you receive any visible cuts or bruises as a result of the accident? ( )YES ( )NO If YES, Where? _____

_____

Did you strike any parts of your body on the interior of the vehicle? ( )YES ( )NO If YES, Explain? _____

_____

Following the collision, did you experience: ( )DIZZINESS ( )NAUSEA ( )CONFUSION/DISORIENTATION ( )HEADACHES
Did your pain begin: ( )IMMEDIATELY ( )HOURS LATER ( )DAYS LATER ( )OTHER _____

INFORMATION ABOUT THE VEHICLE YOU WERE IN:

Year:_____Make (Ex. HONDA):_____ Model (Ex. CIVIC): _____

What was the estimated speed of your vehicle during impact?_____(MPH)
Was your vehicle: ( ) SLOWING DOWN ( ) ACCELERATING ( ) STEADY SPEED ( ) STOPPED ( ) PARKED
Was you vehicle pushed forward after impact? ( )YES ( )NO If YES, How much? ___
Did your vehicle strike any other objects after the crash? _____
_____ Estimated amount of damage to your vehicle? $ _
Estimated damage to other vehicle? ( )NONE ( )MINIMAL ( )MODERATE ( )MAJOR

INFORMATION ABOUT OTHER VEHICLE(S) INVOLVED IN ACCIDENT:

Year: _____ Make (Ex. HONDA): _____ Model (Ex. CIVIC): _____

What was the estimated speed of the other vehicle during impact?_____(MPH)
Was the other vehicle: ( ) SLOWING DOWN ( ) ACCELERATING ( ) STEADY SPEED ( ) STOPPED ( ) PARKED
If more than one other vehicle was involved, please explain. _

_____

_____

HOSPITAL EMERGENCY ROOM QUESTIONS:

Were you taken to a hospital/emergency room after the accident? ( )YES ( )NO DATE (If not same day) / /_____

Name of hospital/emergency room? ___City ___

How did you get to the hospital/emergency room? ( ) AMBULANCE ( )YOURSELF ( )SOMEONE ELSE DROVE YOU

Were X-Rays Taken? ( )YES ( )NO If yes, were X-Rays taken: ( )Laying down ( )Standing ( )Seated

Which areas of your body were X-Rayed? ( )NECK ( )MID BACK ( )LOW BACK ( )OTHER _

_____

Was any treatment administered at the hospital? ( )ICE ( )HEAT ( )CERVICAL COLLAR ( )MEDICATION FOLLOW UP INSTRUCTIONS : __

OTHER HEALTH CARE PROVIDERS SEEN AFTER THE ACCIDENT:

1)Dr. _____ Specialty:_____Referred By: _____

ARE YOU CLAIMING TIME LOSS FROM WORK? _____

IF NOT, THEN SKIP THE FOLLOWING SECTIONS.

QUESTIONS ABOUT YOUR WORK AND SOCIAL HISTORY:

What is your occupation? _____

Employer at time of injury?_____Employers Phone #_____

Employers Address: _____

Is this accident an *on the job injury*? ( )YES ( )NO If YES, have you reported it to your employer? ( )YES ( )NO

Has an *on the job injury claim* been filed? ( )YES ( )NO If YES, what is the claim number? ___

Have you lost time from work as a result of this injury? ( )YES ( )NO If YES, please list dates ___

Date you returned to work or expect to return to work

_____

I am currently working: ( )FULL-TIME ( )PART-TIME_____(HRS/WEEK) ( )REGULAR DUTY ( )LIGHT-DUTY

PLEASE CHECK THOSE ACTIVITIES THAT ARE REQUIRED OF YOU AT WORK:

	LIFTING		OCCAISIONALLY		FREQUENTLY		CONSTANTLY	Up to____lbs
	CARRYING		OCCAISIONALLY		FREQUENTLY		CONSTANTLY	Up to____lbs
	PUSHING		OCCAISIONALLY		FREQUENTLY		CONSTANTLY	Up to____lbs
	PULLING		OCCAISIONALLY		FREQUENTLY		CONSTANTLY	Up to____lbs
	SITTING		OCCAISIONALLY		FREQUENTLY		CONSTANTLY	
	STANDING		OCCAISIONALLY		FREQUENTLY		CONSTANTLY	
	WALKING		OCCAISIONALLY		FREQUENTLY		CONSTANTLY	
	BENDING		OCCAISIONALLY		FREQUENTLY		CONSTANTLY	

	REACHING		OCCAISIONALLY		FREQUENTLY		CONSTANTLY	
	TWISTING		OCCAISIONALLY		FREQUENTLY		CONSTANTLY	
	COMPUTER WORK		OCCAISIONALLY		FREQUENTLY		CONSTANTLY	

PLEASE CHECK THOSE ACTIVITIES THAT CAUSE WORSENING OF YOUR ACCIDENT RELATED INJURY:

	LIFTING		SITTING		TWISTING		HOUSE WORK		
	CARRYING		STANDING		REACHING		YARD WORK		
	PUSHING		WALKING		EXERCISING		DRIVING		
	PULLING		BENDING		COMPUTER WORK		OTHER _____		

SIGNATURE: _____

DATE: _____