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? _____

(If pedestrian) 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

(If cycle) What type of protection did you have? _____

Did the airbag deploy? ☐ Yes ☐ No

Did you come in contact with anything at the time of collision? (Explain) ☐ 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 or cycle 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/cycle moving?	_____
What was the estimated speed of your vehicle/cycle?	_____
What was the extent of the damage to your vehicle?	_____
What was the extent of the damage to the other vehicle/cycle?	_____
In what direction was the other vehicle/cycle moving?	_____
What was the estimated speed of the other vehicle/cycle?	_____
Was your vehicle/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? (Explain)	☐ 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 (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? (if applicable) _____

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? (Explain) ☐ Yes ☐ No
_____

How have your symptoms changed since the accident? ☐ Worsened ☐ Remained the same ☐ Improved