TOTAL SPORTS MEDICINE & ORTHOPEDICS

MOTOR VEHICLE ACCIDENT HISTORY FORM

_____ _____

Name Date of Birth

_____ _____

Body Part Injured Date of Accident

_____

Street or Intersection Accident took place and direction you were traveling

Position in Car - Driver / Front Passenger / Rear Left / Rear Right / Other / Pedestrian

Were you wearing a Seatbelt? ____Yes ____ No How many cars were involved? ____

Speed of your car _____ mph Speed of other car(s) _____ mph

Where was your car hit? Rear - end / Back driver side / Head on / Front Driver Side

Front Passenger Side / Rear Passenger Side / Other

Did Air bags deploy? ___ Yes ____No Did you lose consciousness? ___ Yes ____No

Did any part of your body hit a part of your car? ____No ____ Yes _____

Did you go to the hospital? _____No _____Yes _____

Did you go by Ambulance? ____No _____ Yes

Tests done at Hospital or After accident ___ X-rays ___ Cat Scan ___ MRI___EMG

Have you missed work due to the accident? ____No ____ Yes How long? _____

Have you had any previous car accidents? ____No ____Yes When? _____

What injuries occurred? _____ Are you still treating this/these? ____

Does this involve a lawsuit or do you have an attorney? _____ No _____ Yes

Attorney's Name _____ Attorney Phone# _____