

## 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

\_\_\_\_\_