

Name \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Today's Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Date of accident \_\_\_\_\_ Time of accident \_\_\_\_\_

**YOUR** vehicle model/make \_\_\_\_\_ **OTHER** vehicle model/make \_\_\_\_\_

You were the  Driver  Front seat passenger  Back seat passenger (left)  Back seat passenger (right)

Type of crash  Head-on  I was rear ended  I rear ended other vehicle  Broadside  Other

Explain what happened \_\_\_\_\_

How fast were you going? \_\_\_\_\_ mph How fast was the other vehicle going? \_\_\_\_\_ mph

Top of headrest was even with  base of my skull  top of my head  middle of my neck

Visibility during accident  Good  Poor Road conditions during accident  Good  Poor

Did you see this coming?  Yes  No Was your shoulder harness on?  Yes  No

At impact, your head was  straight forward  turned left  turned right  looking up  looking down

At impact, your body was  sitting straight  turned left  turned right  bent forward

Your state after impact?  unconscious  dazed, needed assistance  shaken, but could function

Did you get out unaided?  Yes  No If NO, explain \_\_\_\_\_

Your symptoms begin?  Right away  Later that day  The next day  Other \_\_\_\_\_

If you haven't already, list your symptoms \_\_\_\_\_

Have you undergone any evaluation and/or treatment for these symptoms?  Yes  No If YES, explain below

Did you have pre-existing problems in the same areas as your complaints?  Yes  No If YES, explain below

Have you ever received treatment for any problems to these same areas?  Yes  No If YES, explain in detail noting how they are different, if at all, from your current complaints \_\_\_\_\_

When was the last treatment? \_\_\_\_\_ Were you fully recovered?  Yes  No

Past surgical history \_\_\_\_\_