MODESTO
PHYSICAL MEDICINE

Automobile Accident History Form

What was the date of your accident? _____
Where were you seated in the car at the time of the accident? _____

Did you hit any part of your body during the collision (head or chest on steering wheel, dash board, or window, etc.) _____If yes, which part and how: _____.

If you were the driver, was your insurance current? _____If you were not the driver, was the driver of your vehicle insured? _____
Was the driver of the other vehicle insured? _____
Did you go to the hospital? _____If yes, which hospital? _____ How did you get to the hospital? _____
Did you receive X-Rays? _____If yes, what part of your body: _____
Did the hospital do an MRI? _____
Did the hospital do a CT Scan? _____
Did you sustain bruises? _____If yes, where? _____

Did you receive any care from any other health professional as a result of the accident? _____ If yes, please name the provider and describe care:

_____

What are your current symptoms?

_____

Were there other people in the car with you? _____

At the time of impact, the vehicle I was in was (circle one) STOPPED SLOWING DOWN ACCELERATING MAINTAINING CONSTANT SPEED TURNING RIGHT TURNING LEFT OTHER (please explain):

_____

_____

Did you have a head rest and was it up or down? _____

Describe the damage to the vehicle that you were in: _____

_____

Describe the damage to the other vehicle: _____

_____

Has an estimate of damages to the vehicle you were in been made? _____ If yes, how much? _____

Do you have an attorney? _____ Who? _____

Doctor's Signature: _____Date: _____