Print Form

SEIVERT
ORTHOPEDICS & SPORTS MEDICINE, PC

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AUTO ACCIDENT HISTORY

Name _____ Age _____ Today's Date _____
Date of Accident _____ Location _____

1. Were you the ☐ driver or ☐ passenger in the ☐ front seat or ☐ back seat?
2. Were you struck from the rear? ☐ yes ☐ no
   If no, how? _____
3. Was anyone else injured in your vehicle? ☐ yes ☐ no
   If yes, how extensively? _____
4. Were you thrown from the car? ☐ yes ☐ no
   Type of vehicle? _____
5. Were you using a seatbelt? ☐ yes ☐ no
6. Were you rendered unconscious? ☐ yes ☐ no
   If yes, how long? _____
7. Did you strike any part of your body on the car? ☐ yes ☐ no
   If yes what part? _____ On What? _____
8. In dollars, state the amount of damage to your vehicle? $ _____
9. What were your symptoms the day of the accident? _____
   _____
10. Did you receive emergency treatment? ☐ yes ☐ no
    Where? _____
    By whom? _____
    Treatment rendered? _____
11. Have you received medical care since the day of the accident? ☐ yes ☐ no
    By Dr. _____ from _____ to _____
    Treatment rendered? _____
    By Dr. _____ From _____ to _____
    Treatment rendered? _____
12. Which treatments have been beneficial? _____
13. How much work have you lost due to the accident? _____
14. Are your presently working? ☐ light duty ☐ full duty ☐ none
15. Please list all x-rays taken due to this injury. Include when, where, and area:
    _____
16. List and describe all previous accidents you have required medical treatment:
    _____