DRMANLOVE.COM optimal health
900A MLK Jr. Blvd Chapel Hill, NC 27514
(919) 942-1930

Automobile Accident History Form

Your Name: _____ Today's Date: _____

Date of Accident: _____ Time of Accident: _____am/pm

Road conditions at the time of accident: ☐ WET ☐ DRY ☐ ICY ☐ OTHER

Did the police come to the accident scene? YES NO

Is there a report? ☐ YES ☐ NO Did you request the report? ☐ YES ☐ NO

Did you go to the hospital? ☐ YES ☐ NO

If yes, what Hospital? _____

How did you get to the hospital? _____

What parts of your body were x-rayed at the hospital? _____

What did the hospital do for your injuries? _____

How long did you stay at the hospital? _____

What bleeding cuts did you sustain during this accident? _____

What bruises did you sustain during this accident? _____

Where were you seated in the vehicle?

☐ DRIVE ☐ FRONT PASSENGER ☐ LEFT REAR ☐ MIDDLE REAR ☐ RIGHT REAR

Were you aware of the approaching collision prior to impact, or did impact catch you by surprise?

☐ AWARE ☐ SURPRISED

Did you lose consciousness (black out) upon impact? ☐ YES ☐ NO How long:

Did you experience a flash of light or explosion in your head? ☐ YES ☐ NO

Did you become one of the following from the accident?

☐ CONFUSED ☐ DISORIENTE ☐ LIGHTHEADED ☐ DIZZY ☐ NAUSEATED

☐ BLURRED VISION ☐ RING/BUZZ IN EARS

If you still have any of those symptoms, which ones? _____

_____

Are you currently suffering from any of the following:

☐ DIFFICULT CONCENTRATING
☐ REDUCED TOLERANCE TO HEAT
☐ REDUCED TOLERANCE TO ALCOHOL
☐ RESTLESSNESS
☐ DIFFICULTY WITH MEMORY
☐ IRRITABLE
☐ SLEEPLESSNESS
☐ CHILLS
☐ FORGETFULNESS

How far is the top of the headrest or seat back from the top of your head (approximately):

_____ inches above or below

Were you wearing a seat belt? ☐ YES ☐ NO

If yes, was it a ☐ LAP SEATBELT or a ☐ SHOULDER-LAP SEATBELT

List the year, make and model of the the vehicle you were in:

Year_____ Make _____ Model_____

Was you car stopped at the time of impact? ☐ YES ☐ NO

If yes, was the driver's foot also on the brake? ☐ YES ☐ NO

If no, then estimate the speed of the vehicle you were in: _____mph

If your vehicle was moving at the time of impact, was it:

Slowing Down? ☐ YES ☐ NO

Gaining Speed? ☐ YES ☐ NO

Traveling at a steady rate of speed? ☐ YES ☐ NO

On what part of the automobile did your following body parts hit?

Head Hit _____ chest hit _____

right/left shoulder hit _____ right/left arm hit _____

right/left hip hit _____ right/left leg hit _____

right/left knee hit_____ other_____

Did you receive any injury or bruise from the seat belt? ☐ YES ☐ NO

If YES then describe: _____

What is the estimated cost damage to the vehicle you were in? $ _____

Which of the following car parts broke during the accident?

☐ WINDSHIELD ☐ FRONT SEAT BACK ☐ RIGHT/LEFT SIDE WINDOW

☐ STEERING WHEEL ☐ OTHER

Was the trunk of your body pointed straight forward at the time of the collision? ☐ YES ☐ NO

If no, how was it turned? _____

Was you head pointed straight forward? ☐ YES ☐ NO

If no, what direction was it turned and by how much?_____

What is the year, make and model of the the other vehicle?

Year _____ Make _____ Model_____

Was the other vehicle moving at the time of the collision ☐ YES ☐ NO

If yes, what was its approximate speed? _____mph

If the other vehicle was moving at the time of the collision, was it:

☐ SLOWING DOWN ☐ GAINING SPEED ☐ TRAVELING AT A STEADY SPEED

Please describe, to the best of your knowledge, what happened during this accident:

_____

_____

_____

_____

_____

Thank you for taking the time to fill out this form.