**Total 98 REHAB**

**AUTO ACCIDENT HISTORY**

Name: Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Accident:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# INFORMATION ABOUT THE MOTOR VEHICLE ACCIDENT:

City where accident occurred Were you the: ( ) DRIVER ( )PASSENGER ( )PEDESTRIAN

Were you struck from: ( )FRONT ( )REAR ( )LEFT SIDE ( )RIGHT SIDE

Were you wearing a seatbelt with a shoulder harness? ( )YES ( )NO

Did Airbags Deploy? ( ) YES ( ) NO If YES, were you struck by Airbags? ( )YES ( )NO

Road conditions were: ( )DRY ( )WET ( )ICY ( )SNOW

Did the police show up to the scene? ( )YES ( )NO

Year: Make (Ex. HONDA):

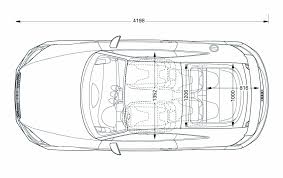
Model (Ex. CIVIC):

Was your vehicle: ( )SLOWING DOWN ( )ACCELERATING ( STEADY SPEED ( STOPPED ( PARKED

Please describe the accident (i.e., Rear‐ended, Side‐swiped, Head‐on etc.)

Did your vehicle strike any other objects after the crash?

Estimated Property Damage to your vehicle? $



**HOSPITAL EMERGENCY ROOM QUESTIONS:**

Were you taken to a hospital/emergency room after the accident? ( )YES ( )NO DATE (If not same day) / /

Name of hospital/emergency room? City

How did you get to the hospital/emergency room? ( ) AMBULANCE ( ) YOURSELF ( ) SOMEONE ELSE DROVE YOU

Were X‐Rays Taken? ( )YES ( )NO If yes, were X‐Rays taken: ( ) Laying down ( ) Standing ( ) Seated

Which areas of your body were X‐Rayed? ( )NECK ( )MID BACK ( )LOW BACK ( )OTHER

Was any treatment administered at the hospital? ( )ICE ( )HEAT ( )CERVICAL COLLAR ( )MEDICATION

FOLLOW UP INSTRUCTIONS:

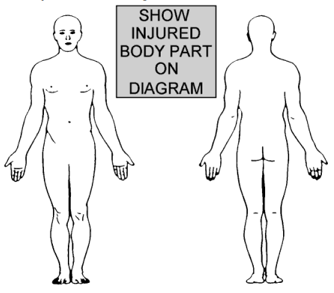
Who was at fault? ( ) Driver of other vehicle ( )Driver of my vehicle ( )Myself ( )Don’t Know

Did you receive any visible cuts or bruises as a result of the accident? ( ) YES ( )NO If YES, Where?

Did you strike any parts of your body on the interior of the vehicle? ( ) YES ( )NO If YES, Explain?

Following the collision, did you experience: ( ) DIZZINESS ( )NAUSEA ( )CONFUSION/DISORIENTATION ( )HEADACHES

Did your pain begin: ( )IMMEDIATELY ( )HOURS LATER ( )DAYS LATER ( )OTHER



# OTHER HEALTH CARE PROVIDERS SEEN AFTER THE ACCIDENT:

1. Dr. Specialty: Referred By:

Date first seen: ( / / ) Treatment type:

Treatment frequency/duration Currently treating? ( )YES ( )NO

Any disability? ( ) YES ( ) NO If YES, please describe

Special tests (X‐Rays, MRI, CT): Did treatments help? ( )YES ( )NO

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Date first seen: ( / / ) Treatment type:

Treatment frequency/duration Currently treating? ( )YES ( )NO

Any disability? ( ) YES ( ) NO If YES, please describe

Special tests (X‐Rays, MRI, CT): Did treatments help? ( )YES ( )NO

# QUESTIONS ABOUT YOUR WORK AND SOCIAL HISTORY:

What is your occupation?

Employer at time of injury? Employers Phone #?

Employers Address:

Have you reported it to your employer? ( )YES ( )NO

Has an *on the job injury claim* been filed? ( )YES ( )NO If YES, what is the claim number?

Have you lost time from work as a result of this injury? ( )YES ( )NO If YES, please list dates

Date you returned to work or expect to return to work

I am currently working: ( )FULL‐TIME ( )PART‐TIME (HRS/WEEK) ( )REGULAR DUTY ( )LIGHT‐DUTY

# PLEASE CHECK THOSE ACTIVITIES THAT ARE REQUIRED OF YOU AT WORK:

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | LIFTING |  | OCCAISIONALLY |  | FREQUENTLY |  | CONSTANTLY | Up to lbs |
|  | CARRYING |  | OCCAISIONALLY |  | FREQUENTLY |  | CONSTANTLY | Up to lbs |
|  | PUSHING |  | OCCAISIONALLY |  | FREQUENTLY |  | CONSTANTLY | Up to lbs |
|  | PULLING |  | OCCAISIONALLY |  | FREQUENTLY |  | CONSTANTLY | Up to lbs |
|  | SITTING |  | OCCAISIONALLY |  | FREQUENTLY |  | CONSTANTLY |  |
|  | STANDING |  | OCCAISIONALLY |  | FREQUENTLY |  | CONSTANTLY |  |
|  | WALKING |  | OCCAISIONALLY |  | FREQUENTLY |  | CONSTANTLY |  |
|  | BENDING |  | OCCAISIONALLY |  | FREQUENTLY |  | CONSTANTLY |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | REACHING |  | OCCAISIONALLY |  | FREQUENTLY |  | CONSTANTLY |  |
|  | TWISTING |  | OCCAISIONALLY |  | FREQUENTLY |  | CONSTANTLY |  |
|  | COMPUTER WORK |  | OCCAISIONALLY |  | FREQUENTLY |  | CONSTANTLY |  |

**PLEASE CHECK THOSE ACTIVITIES THAT CAUSE WORSENING OF YOUR ACCIDENT RELATED**

**INJURY:**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | LIFTING |  | SITTING |  | TWISTING |  | HOUSE WORK |  | |  |
|  | CARRYING |  | STANDING |  | REACHING |  | YARD WORK |  | |  |
|  | PUSHING |  | WALKING |  | EXERCISING |  | DRIVING |  | |  |
|  | PULLING |  | BENDING |  | COMPUTER WORK |  | OTHER | |  |  |

Do you have an Attorney? ( )Yes ( )No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SIGNATURE:** **DATE:**