SpineCare LLC **ID #: _____**
3110 Gilbert St. Marinette, WI 54143
Automobile Accident History Form

Patient Name: _____ Date: _____SS#:_____

Vehicle Insurance Information

Name of Insurance Company: _____

Address: _____

Insured's Name: _____ Insured SS #: _____ Insured DOB:_____

Policy #: _____ Claim #: _____

Name of Claim Representative: _____ Phone #:_____

_____

Attorney Information

Attorney Name: _____ Name of Law Firm: _____

Attorney Address: _____

Attorney Phone #: _____ Attorney Email: _____

_____

Accident Information

1. Date of injury: _____ Time of Injury :_____am/pm State of Injury: _____
2. Road conditions at time of the accident? ☐ Wet ☐ Dry ☐ Icy ☐ Other _____
3. Did the police come to the accident scene? ☐ Yes ☐ No Is there a police report? ☐ Yes ☐ No
4. Where were you seated in the vehicle? ☐ Driver ☐ Front Passanger ☐ Rear Passanger
5. How far is the top of the headrest or seat back from the top of your head? ___Inches ☐ Above ☐ Below
6. Were you wearing a seatbelt? ☐ Yes ☐ No If yes, was it a ☐ lap seat belt or ☐ Shoulder- Seatbelt
7. Did you receive any injury or bruises from the seat belt? ☐ Yes ☐ No
   If yes, where: _____
8. Were you aware of the approaching collision prior to impact? ☐ Aware ☐ Suprised ☐ Other _____
9. What bleeding/cuts did you sustain from the accident? _____
10. What bruises did you sustain from the accident? _____
11. Did you lose consciousness (black out) upon impact? ☐ Yes ☐ No If yes for how long? _____
12. Did you experience a flash of light or explosion in your head? ☐ Yes ☐ No
13. Did you become:(Check all that apply) ☐ Confused ☐ Disoriented ☐ Light headed ☐ Dizzy
    ☐ Nauseated ☐ Blurred Vision ☐ Ring/ Buzzing in ears
14. Do you still have any of the above symptoms currently? ☐ Yes ☐ No
    If yes please list which ones:_
15. Are you currently suffering from any of the following? (check all that apply)
    ☐ Restfullness ☐ Irritable ☐ Sleeplessness ☐ Forgetfullness ☐ Difficulty Concenrating
    ☐ Difficulty with memory ☐ Reduced tolerance to heat ☐ Reduced tolerance to alcohol

Hospital Information

1. Did you go to the hospital? ☐ Yes ☐ No
   If yes, what is the name and city of the hospital? _____
2. How did you get to the hospital? ☐ Ambulance ☐ Self ☐ Other _____
3. Did you get X-rays? ☐ Yes ☐ No If yes, list of X-rays: _____
4. How long did you stay at the hospital? _____

Your Vehicle Information

1. List the year, make and model of the vehicle you were in: _____ Year _____Make _____Model
2. What is the estimated cost of damages to the vehicle you were in? $_____
3. Was your car stopped at the time of impact? ☐ Yes ☐ No
   If yes, was the driver's foot on the brake? ☐ Yes ☐ No
   If no, then estimate the speed of the vehicle you were in: _____ mph
4. If you vehicle was moving at the time of impact was it: ☐ Slowing Down ☐ Gaining Speed ☐ Steady
5. On what part of the automobile did the following body parts hit? (list below)
   Head _____ Chest _____
   Right/ Left Shoulder_____ Right/Left Arm _____
   Right/Left Hip _____ Right/Left Leg _____
   Right Left Knee_____ Other: _____
6. Which of the following car parts broke during the accident?
   ☐ Windshield ☐ Front Seat Back ☐ Right/Left Window ☐ Steering wheel ☐ Other _____
7. Was the trunk of your body pointed straightforward at the time of the collision? ☐ Yes ☐ No
   If no, what direction was it turned? _____
8. Was your head pointed straightforward? ☐ Yes ☐ No If no what direction was it turned? _____

Other Vehicle Information

1. What was the year, make, model of the other vehicle? _____Year _____Make _____Model
2. Was the other vehicle moving at the time of the collision? ☐ Yes ☐ No If yes, approx speed. _____mph
3. If the other vehicle was moving at the time of the collision was it?
   ☐ Slowing Down ☐ Gaining Speed ☐ Steady speed ☐ Unsure

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

_____

_____

_____

_____ _____

Patient's Signature *Date*