WILLIAMSTON WELLNESS, PLLC
AUTO ACCIDENT HISTORY FORM

Today's Date _____

PATIENT NFORMATION:

Name_____Age_____Date of Birth____/____/_____Gender: M F T

Home Address_____City_____State_____Zip_____

Home/Cell Phone_____Alt. Phone_____

Email_____

Auto Insurance Co. Name_____Claim#_____

Name of Adjustor_____Phone_____

Address_____

3rd Party Insurance Co Name_____Claim#_____

Name of Adjustor_____Phone_____

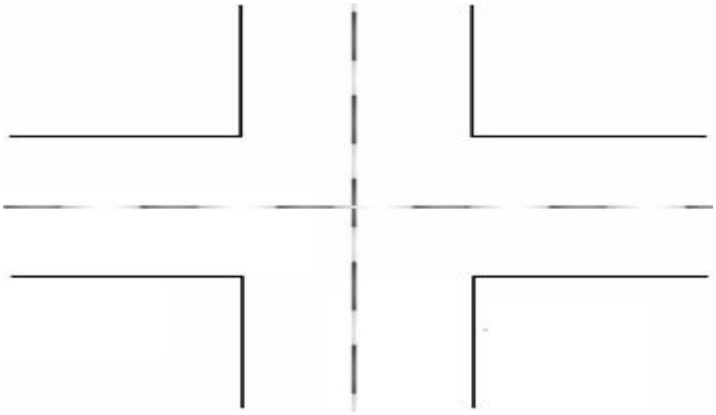
Attorney Name_____Phone_____

ACCIDENT DETAILS:

Date of Accident ____/_____/_____ Time of Accident _____ ☐ AM ☐ PM Road Condition: ☐ Wet ☐ Dry ☐ Icy

You were the ☐ DRIVER ☐ FRONT PASSENGER ☐ BACK PASSENGER or ☐ PEDESTRIAN

Please describe the accident:_____



Make/Model/Year of your Vehicle_____Make/Model/Year other Vehicle_____

Did your car strike the other(s) involved? ☐ YES ☐ NO Did the other car strike yours? ☐ YES ☐ NO

What part of the vehicle received the impact? ☐ FRONT ☐ REAR ☐ RIGHT SIDE ☐ LEFT SIDE

Were you wearing seatbelt ☐ YES ☐ NO

Did your vehicle go off the road? ☐ YES ☐ NO Did your vehicle roll over? ☐ YES ☐ NO

Did you lose consciousness (black out) upon impact? ☐ Yes ☐ No If yes, how long were you out?_____

Did any body parts strike something in the car? _____

Were police at the accident scene? ☐ Yes ☐ No Is there an accident report? ☐ Yes ☐ No

Who was ticketed?_____

Did you go to the hospital? ☐ Yes ☐ No By ambulance? ☐ Yes ☐ No

INJURY DETAILS:

List exams and tests you received at the hospital if any_____

_____

Diagnosis, treatment, medication by hospital, if any_____

_____

Please list any other doctors or health care practitioners you have seen for this accident.

_____

_____

_____

List the extent of injuries as you know them_____

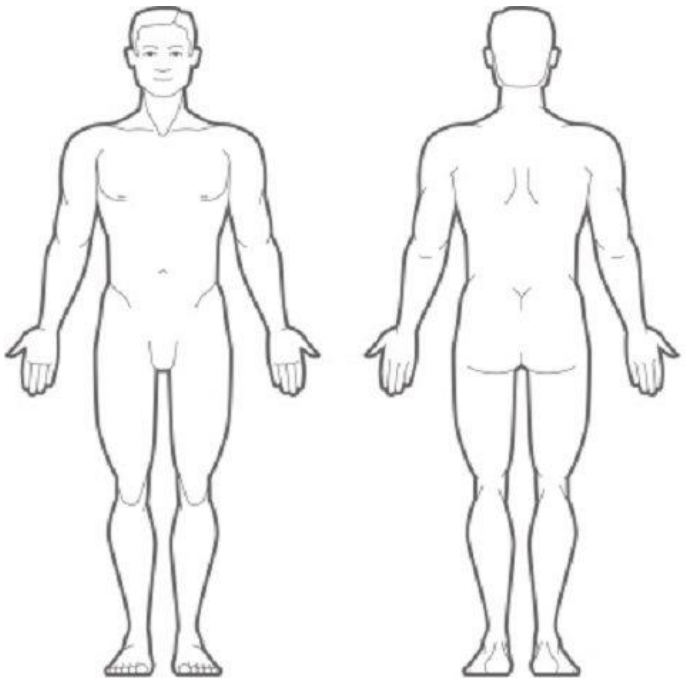
_____

_____

Check any symptoms you have experienced since the accident:

- ☐ HEADACHE
- ☐ DEPRESSION
- ☐ LOSS OF TASTE
- ☐ LIGHT BOTHERS EYES
- ☐ DIARRHEA
- ☐ HEAD SEEMS HEAVY
- ☐ COLD FEET
- ☐ LOSS OF MEMORY
- ☐ SLEEPING PROBLEMS
- ☐ FAINTING
- ☐ BACK PAIN
- ☐ FACE FLUSHED
- ☐ CONSTIPATION
- ☐ NUMB FINGER
- ☐ FEVER
- ☐ NUMBNESS IN TOES
- ☐ COLD SWEATS
- ☐ DIZZINESS
- ☐ FATIGUE
- ☐ STOMACH UPSET
- ☐ BUZZING IN EARS
- ☐ NECK PAIN
- ☐ PINS & NEEDLES IN ARMS
- ☐ STIFF KNECK
- ☐ EAR RINGING
- ☐ COLD HANDS
- ☐ LOSS OF BALANCE
- ☐ PINS & NEEDLES IN LEGS
- ☐ TENSION
- ☐ NERVOUSNESS
- ☐ LOSS OF SMELL
- ☐ IRRITABILITY
- ☐ SHORTNESS OF BREATH
- ☐ CHEST PAIN
- ☐ OTHER_____

Please circle any areas of pain, injury, tension, or restriction of movement.



Overall, at this time, is your condition: ☐ Becoming worse ☐ Remaining the same ☐Improving

WORK LOSS DETAILS:

At the time of this injury did you have a job? ☐ Yes ☐ No

Employer/Address _____Occupation _____

Did you miss any work because of your injuries? ☐ Yes ☐ No From:_____/_____/_____ To:_____/_____/_____

Returned to work on: _____/_____/_____ Light or Full Duty?_____

Did you lose your job because of your injuries? ☐ Yes ☐ No Did you change jobs because of your injuries? ☐ Yes ☐ No

Patient Signature_____**Date**_____