ALL STAR HEALTH
SPINE & SPORTS CARE

Automobile Accident History

Patient Name: _____ Date of the accident: ____/____/____

Give time of accident: _____ [ ] AM [ ] PM What State: _____ Who was cited for accident: _____
Was the vehicle a company car? [ ] YES [ ] NO Did the accident happen while on company time? [ ] YES [ ] NO

Your vehicle was a: [ ] Compact [ ] Mid-size [ ] Full-size [ ] Small truck [ ] Full truck [ ] Mini-Van [ ] SUV [ ] Other: _____

Other vehicle was a: [ ] Compact [ ] Mid-size [ ] Full-size [ ] Small truck [ ] Full truck [ ] Mini-Van [ ] SUV [ ] Other: _____

What were the road conditions at time of accident: _____

Where was your car struck? [ ] Front [ ] Rear [ ] R-side [ ] L-side [ ] R-Front Corner [ ] L-Front Corner
[ ] R-Back Corner [ ] L-Back Corner [ ] Other: _____

What is the estimated damage to your vehicle: $_____ Total loss: [ ] Yes [ ] No

You were heading? [ ] North [ ] South [ ] East [ ] West on: _____
(street or highway)

Other vehicle was heading? [ ] North [ ] South [ ] East [ ] West on: _____
(street or highway)

Please explain in detail how your accident occurred? _____

_____

_____

Number of people in the car including yourself? _____ Your position in the car? [ ] Driver [ ] Passenger

If you were the passenger which seat were you in? [ ] Front Seat Right Side [ ] Back Seat Left Side [ ] Back Seat Right Side

How fast was your vehicle moving upon impact? _____ MPH _____ STOPPED

How fast was the other vehicle(s) moving upon impact? _____ MPH _____ STOPPED

Were the brakes applied at the time of impact? [ ] YES [ ] NO Did the seat break at the time of impact? [ ] YES [ ] NO

Did the airbags deploy at the time of impact? [ ] YES [ ] NO Were your seatbelts on at the time of impact? [ ] YES [ ] NO

Were the Police notified? [ ] YES [ ] NO Did your head strike the windshield or any objects? [ ] YES [ ] NO

Did you feel pain immediately after the accident? [ ] YES [ ] NO [ ] Later that day [ ] Next day When? _____

What were your immediate symptoms after the accident? _____

Have you ever had any complaints in the involved area before? [ ] YES [ ] NO

Since the injury, are your symptoms [ ] Improving [ ] Getting Worse [ ] The same

Did you lose consciousness at the time of the accident? [ ] YES [ ] NO

Where did you go after the accident? [ ] Work [ ] Home [ ] Hospital [ ] Chiropractor [ ] Family Doctor

If you sought Medical care, where did you go? _____

If you sought Medical care, how did you get there? [ ] Self [ ] Friend [ ] Ambulance [ ] Helicopter

Have you retained an attorney? [ ] NO [ ] YES Name: _____ Phone #: _____

6625 S. Rural Rd., Ste. 104 • Tempe Arizona 85283• Phone: 480-833-4515• Fax: 480-833-5078
2730 S. Val Vista Dr., Ste. 188 Gilbert• Arizona 85295 • Phone 480-324-0244• Fax: 480-324-0589
www.all-star-health.com