Accident & Trauma /
828 Wall Street
Norman, OK 73069

Date:________________
Drivers License #________________
Email: ________________

AUTO ACCIDENT HISTORY FORM

PERSONAL INJURY HISTORY INFORMATION

Name: ________________ SSN: ________
Date of Birth____/____/____ Age: ______ Gender: M F Marital Status: S M W D
Home Address: ________________
City: ____________ State: ________ Zip Code: ________
Home Phone: ________ Work: ________ Cell: ________
Employer: ____________ Occupation/Title: ________
Spouse: ____________ Spouse's Occupation: ________
Emergency Contact: ________ Phone: ________ Relationship: ________

LIABILITY INFORMATION:

Has the accident been reported to the liability insurance company? ❑ Yes ❑ No
Have you been contacted by any insurance company? ❑ Yes ❑ No
Insurance Carrier: ____________ Phone:________
Name of Insured: ____________ Claim #:________
Name of Adjuster: ____________ Phone: ________ Fax#:________
Address for claim(s):____________ City: ________ State:______ Zip:______
Do you have a copy of the police report? ❑ Yes ❑ No **If yes, please provide us with a copy**

MEDPAY INFORMATION:

Have you contacted your Auto Insurance Company about the accident? ❑ Yes ❑ No
Do you have (MedPay) medical payments coverage through your Auto Insurance Company? ❑ Yes ❑ No
Insurance Carrier: ____________ Phone: ________
Name of Adjuster: ____________ Claim #: ________
Address: ____________ City: ________ State: ______ Zip: ______

AUTO ACCIDENT INFORMATION:

Date of Accident: ________ Time: ______ AM/PM Location of Accident: ________
City/State: ____________ Closest bisecting street/town: ________
Driver of car: ____________ Who owns vehicle? ________
Year/Make/Model of YOUR car: ________ Year/Make/Model of OTHER car: ________
Where were you seated? ❑ Driver ❑ Front center passenger ❑ Front right passenger
❑ Rear left passenger ❑ Rear center passenger ❑ Rear right passenger ❑ Pedestrian
Number of people in your vehicle: ______ Other vehicle: ______ Number of cars involved: ______
Road conditions at time of accident: ❑ Wet ❑ Dry ❑ Icy ❑ Clear ❑ Other________
Visibility at time of accident: ❑ Good ❑ Fair ❑ Poor ❑ Other________
Where was the vehicle struck ❑ Right ❑ Left ❑ Rear ❑ Front ❑ Side ❑ Other ________
Type of accident: ❑ Head-on collision ❑ Rear-end collision ❑ Broad-side collision ❑ Front impact
Non-collision (describe) ____________
Did you see the accident coming? ❑ Yes ❑ No; Did you brace for the impact? ❑ Yes ❑ No;
Did car have a headrest? ❑ Yes ❑ No; Did your head hit the head rest? ❑ Yes ❑ No;
Airbags deployed ❑ Yes ❑ No ❑ Driver ❑ Front ❑ Side
At the time of the impact, was your vehicle: ❑ Stopped ❑ Moving; If moving how fast were you going? ___ mph
Estimate how fast other car was going? ______ mph; Which vehicle is responsible for accident? ________
Did the vehicle flip over? ❑ Yes ❑ No; Were you thrown out of your seat? ❑ Yes ❑ No
In your own words describe the accident:____________
____
Did you receive any cuts or lacerations? ❑ Yes ❑ No; If yes, where? ________
Did you sustain any bruising because of accident? ❑ Yes ❑ No; If yes, where: ________
Head or body position at the time of impact: ❑ Head straight ahead ❑ Head turned to left/right
❑ Head looking back ❑ Body straight in sitting position ❑ Body rotated left/right ❑ Other________
Did you feel immediate pain? ❑ Yes ❑ No; If yes, where? ________

Did you strike anything in the vehicle at time of impact? ❑ Yes ❑ No; If yes, what body part of your body struck what? ie: Head, Chest, Chin, Right / Left Shoulder, Right / Left Knee, Right / Left ankle, Right / Left wrist

❑ Steering Wheel ______________ ❑ Dashboard ________________ ❑ Windshield ________________
❑ Roof ____________________ ❑ Driver Side Door ____________ ❑ Passenger Door ____________
❑ Driver Side Window __________ ❑ Passenger Window __________ ❑ Other ____________________

As a result of the accident you were: ❑ Unconscious ❑ Dazed/Dizzy ❑ In Shock ❑ Unphased ❑ Disoriented ❑ Nervous ❑ Nauseous ❑ Upset ❑ Weak ❑ Other: ______________________________

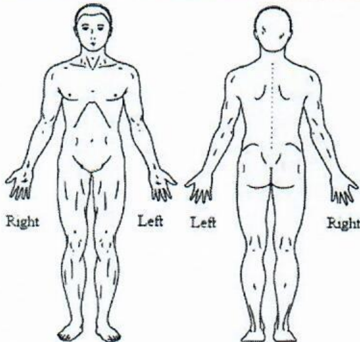
Were you able to walk unaided after the accident ❑ Yes ❑ No
If no, why not? ____

Did you go to the emergency room/hospital after the accident? ❑ Yes ❑ No
If yes were you taken by: ❑ Ambulance ❑ Driven by another person ❑ Able to take yourself
Hospital / Clinic Name: ________________________ Dr. Name(s) ____________________
What treatment was given? ❑ none ❑ x-rayed ❑ given stitches ❑ given pain medication ❑ placed in cervical collar ❑ given instructions regarding sprains and strains ❑ Other ____________________
If x-rays what area(s) ____
Please describe how you felt immediately after the accident: ______________________________
The next day: ____
List all medications/reasons you are currently taking because of the accident: ____________________
____
Have you seen any other doctor for this accident? ❑ Yes ❑ No; Are you still treating with him/her? ❑ Yes ❑ No
If yes, what treatment was given: ______________________________
____

Check symptoms since the accident: ❑ Headache ❑ Blurred vision ❑ Memory loss ❑ Neck pain ❑ Dizziness ❑ Jaw/TMJ pain ❑ Loss of Sleep ❑ Muscle spasms ❑ Loss of balance ❑ Finger/Toe Numbness ❑ Mid back pain ❑ Low back pain ❑ Ringing in the ears ❑ Confusion ❑ Fainting ❑ Extremity pain ❑ Loss of smell ❑ Loss of taste

Indicate your ability to perform the following activities because of this injury using codes:
N – Normal, L – Limited, D – Difficult, P – Painful, U – Unable

___ Walking short distance
___ Lying on side with knees bent
___ Standing for more than 1 hour
___ Bending over forward
Getting into/out of car
____ Lying flat on stomach
____ Lying on back
____ Coughing/Sneezing
____ Turning over in bed
____ Sex Activity
____ Dressing Self
____ Kneeling
___ Bending forward to brush teeth
____ Gripping
____ Reaching
____ Sitting at table
____ Stooping
____ Pushing
____ Pulling



CIRCLE AREA(S) OF PAIN

Severity of Pain: List region of pain and circle severity
1 low pain, 4 moderate pain, 7 intense pain, 10 emergency

EX ______NECK______
1 2 3 4 5 6 7 8 9 10

1. ____________________
1 2 3 4 5 6 7 8 9 10

2. ____________________
1 2 3 4 5 6 7 8 9 10

3. ____________________
1 2 3 4 5 6 7 8 9 10

4. ____________________
1 2 3 4 5 6 7 8 9 10

5. ____________________
1 2 3 4 5 6 7 8 9 10

MEDICAL HISTORY

What medications/drugs are you taking (not related to this injury)? ____________________
Date of last physical examination? ______________________________
What operations have you had? Please include dates: ____________________

By signing below, I certify that the information I have written in all these pages is correct to the best of my knowledge.

____
Print Name

____
Patient Signature (or parent / guardian)

____
Date