

Vehicle Accident History Form

If you are a new or existing patient and have been in a motor vehicle accident, or were struck by a vehicle, please complete this 4 page accident report form and bring the completed form with you to your consultation.

To help save you time when you first visit our office, you may complete this accident history form in the comfort of your own home.

Simply bring the forms with you to the office and we'll get started right away, otherwise, please allow an additional 10-15 minutes to complete the forms at our office.

Please complete all 4 pages of this form.

Thank you.

VEHICLE ACCIDENT HISTORY FORM

Today's Date: _____

Name: _____
 (Last Name) (First Name) (Initial)

Date of Accident: _____ Time of Accident: _____

ICBC Claim #: _____ Claim Centre _____

Adjuster's Name: _____



Were you the Driver: Yes ___ No ___

If you were a passenger, where were you seated? _____

Make and model of vehicle you were riding in: _____

Make and Model of Other Vehicle #1: _____

Vehicle #2: _____

Briefly describe the Accident: _____

Please Draw a Diagram of how the accident occurred on the back of this page.

Road conditions at the time of the accident: Wet ___ Dry ___ Icy ___

Did the Police come to the Accident Scene: Yes ___ No ___

Were any Citations Given: Yes ___ No ___

Who was deemed 'At Fault' _____

Were you stopped or moving at the time of the accident _____

Did you see the accident about to happen? _____

Were you sitting straight forward at the time of the collision? _____ If no, please describe your position _____

What was the position of your head at impact (turned left/right, straight)? _____

Were you trying to grab or restrain anyone or anything? _____

Did you brace yourself for the accident? _____

Was your foot on the brake? _____

If your vehicle had an airbag, did it deploy? _____

Did any part of your body hit the inside of the vehicle? _____ If yes, please describe _____

What areas of your body were cut or bruised _____

Did you lose consciousness upon impact? _____

Were you able to get out of your vehicle by yourself? _____

Were you dizzy? _____ Were you disoriented? _____

Were you taken to the Hospital? _____ Hospital Name _____

How did you get to the Hospital? _____

While at the Hospital, what tests, X-rays, etc. were done _____

Were you given any instructions/medications? _____

Describe any pain or discomfort immediately following the accident:

Describe any pain or discomfort later that same day:

Describe your discomfort the following day:

What treatment or therapies have you tried since the accident, and how would you describe the success of these:

What has been the progression of symptoms from the time of the accident until now?

Have you experienced any of the symptoms you described prior to the accident?

Have you been in previous auto accidents? List the year and briefly explain what happened and to what extent you were injured in each accident:

Are there any residuals, pain, or discomfort from a previous accident or injury that was bothering you before or that have worsened since this accident? Explain:

Have you missed time from work as a result of the injuries sustained in the accident?

Please describe your job duties: _____

What duties at work, if any, aggravate the injuries you sustained: _____

What duties at home aggravate the injuries you sustained: _____

Are there any leisure or social activities that aggravate your injuries _____

If you have contacted a lawyer concerning this accident, what is the lawyer's name and telephone number: _____



Is there any other information you wish this office to be aware of? _____

The above information given by me is accurate and complete:

Signature of patient or guardian

Date