MendelsonKornblum
Physical Therapy & Rehabilitation

Auto Accident Form

Patient name: **Date:**

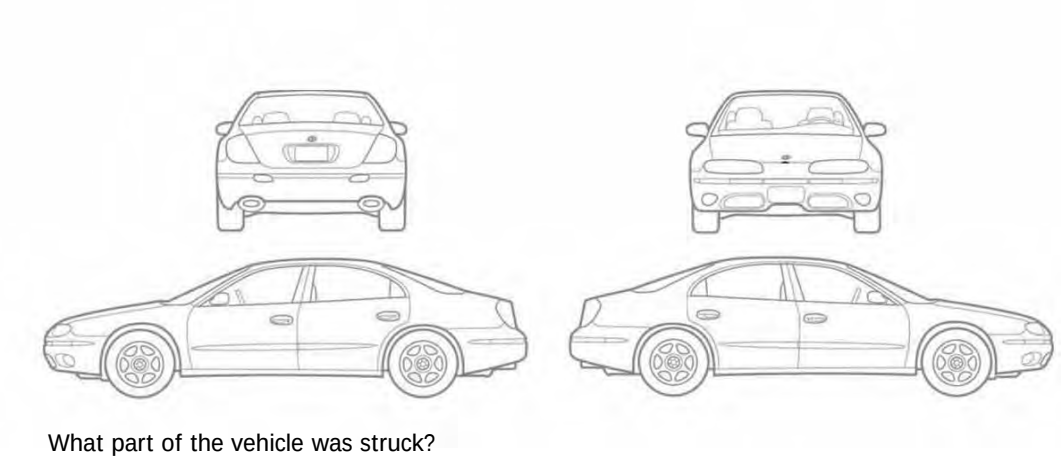
Date of the accident:

Make and model of the vehicle: ☐ Automobile ☐ Truck ☐ Commercial ☐ Motorcycle ☐ Bus

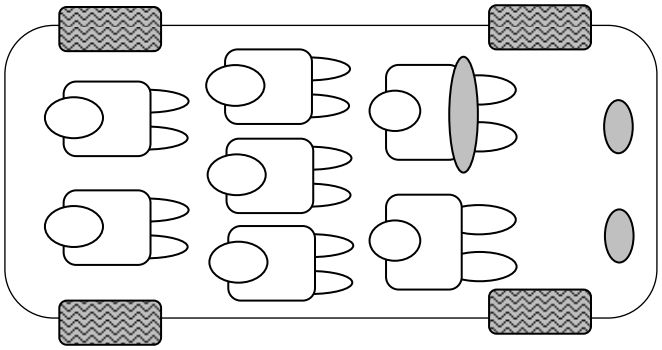
Was the vehicle drivable after the accident? ☐ Yes ☐ No

Cost of damage to the vehicle $

Owner of the vehicle?



What part of the vehicle was struck?



Please circle which seat were you sitting in.

Auto Specifics:

Did the airbags deploy? ☐ Yes ☐ No

Were you wearing a seatbelt? ☐ Yes ☐ No

Did you go to the hospital after the injury? ☐ Yes ☐ No

If Yes, was it immediately, hours later, days later, or by ambulance?

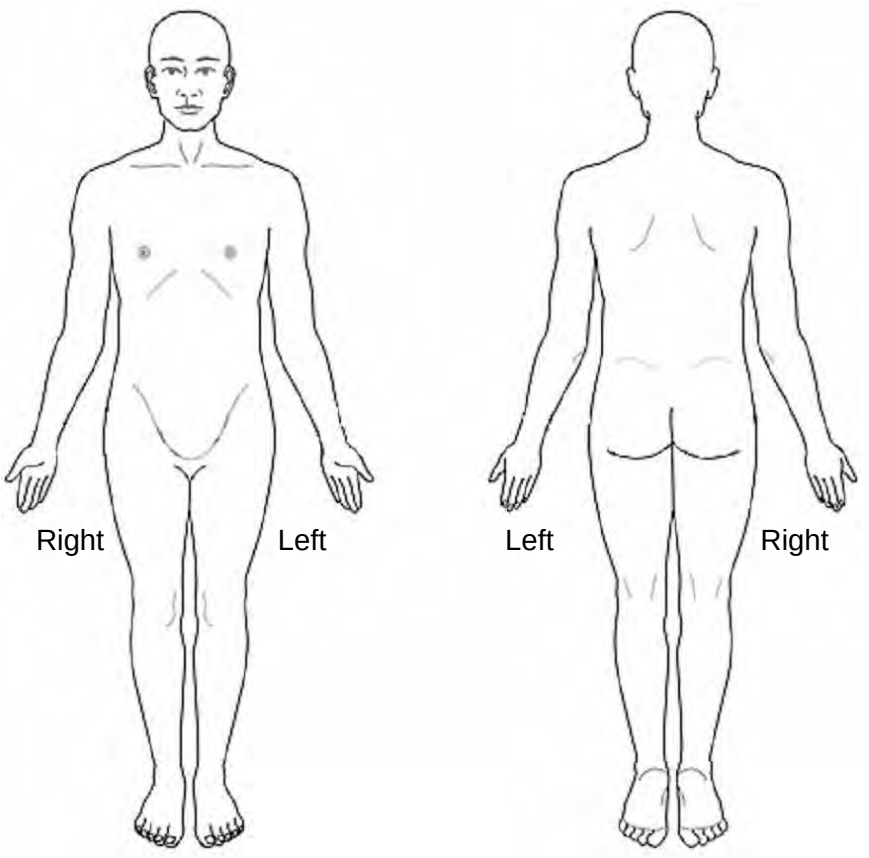
What hospital did you go to?

When, after the accident, did the body part start hurting?

Have you ever been treated for the body part before the accident? ☐ Yes ☐ No

If Yes, what kind of treatment?

Please draw where you are having symptoms.



Patient Information:

Are you on disability or SSI? ☐ Yes ☐ No

If Yes, for what reason?

Any prior auto accidents with injuries?

Any previous workman's comp cases?

Any previous slip and fall / premise cases?

Social:

Were you employed before the accident? ☐ Yes ☐ No

Are you currently employed? ☐ Yes ☐ No

When was the last time you worked?

Do you have a history of anxiety or depression? ☐ Yes ☐ No

If Yes, what kind of treatment did you receive?

Do you smoke? ☐ Yes ☐ No

If Yes, for how long?

Date: _____