SIX POINTS PHYSICAL THERAPY

AUTO ACCIDENT INFORMATION

Name : ______________________________ Today's Date : ___/___/____

Social Security # ______-_____-_____ Date of Birth ___/____/____

Current Address : ____________________________ Occupation:___________________
____________________________ ___________________

Phone : ( ) ______________________ Message Phone : _________________

Employer: ___________________________________Wk # ________________________

ACCIDENT DETAILS :

Date Of Accident : _____/_____/____ Time of Day : _______AM – PM
Location Of Accident : ____
Were you a ______________Driver ______________Passenger _____________ Pedestrian
Which way were you looking ? ___________ Straight _________ Left _________ Right
Was your vehicle ______ Stopped to make a turn ___________ Stopped for a traffic signal
______ Parked ________ Moving at the time of impact
Other : ____

Did your body strike anything in the car ? _______
Were you wearing a seat belt ? _________
Do you have any health problems ? _____________________
List any Medication you are taking : ____
____
Describe in detail how accident happened :
____
____
____
____
____

Were you rendered unconscious as a result of the accident ? ______________
Were you taken to the hospital ? ______________ By ambulance or private car ? _________________
Were you taken to the hospital immediately after the accident ? ____________________________
If not, how much time elapsed before taken to the hospital ? _______________________________
Women only are you pregnant or is there any possibility you may be ? ______________________
What part of your body hurts? ____
____
____
____