ELIXIA
wellness group

MOTOR VEHICLE ACCIDENT INJURY HISTORY FORM

Name: _____ Date: _____

HISTORY

Date of Injury: _____ Time of Day: _____ Weather Conditions: _____

How did the accident happen?

_____

_____

_____

_____

_____

Y / N Were there witnesses? If yes, provide their names: _____

Y / N Was a police report filed?

Y / N Did you contact **your** insurance company on this claim?

Y / N Have they sent you a PIP form? If yes, have you returned it? Y / N

Y / N Have you been contacted by a claim representative/insurance adjuster?

Y / N Do you have an attorney who has advised you on this case?

If yes, please provide name, address: _____

Name of **your** insurance company_____

Insurance Adjuster's: Name_____ Phone #_____

Your Claim # _____ PIP Max_____

FOR MOTOR VEHICLE ACCIDENTS: (please circle or fill in blanks)

Were you the:	Driver	Passenger	Pedestrian	
Your location in car:	L Front	R Front	R Rear	L Rear
Cross streets/location of accident: _____				
You were headed:	North	South	East	West
The other vehicle was going:	North	South	East	West
The impact was from:	Front	Rear	Right	Left
At impact you were looking:	Right	Left	Straight ahead	Unknown
If driving, were hands on the wheel?		Y	N	N/A
If driving, was foot on brake?		Y	N	N/A
Did head hit headrest?		Y	N	N/A
Were you braced for impact?		Y	N	N/A
Were you wearing seatbelt?	Lap belt only		Lap/Shoulder Combo	No
Were you doing something at impact?		Y	N	Describe: _____
Did you strike anything in the car:	No	If yes, specify: _____		
What part(s) if body struck above: _____				
Did you lose consciousness?		Y	N	If yes, how long? _____

FOLLOWING THE ACCIDENT

How you felt immediately: _____ Later that day: _____
How you felt the next day: _____
Did you go to urgent care/emergency? No Yes – Where? _____
How did you get there? Ambulance Private car – whose? _____
Treatment rendered: _____
X-ray or MRI taken? No Yes – Which body part(s)? _____
List the extent of your injuries as you know them: _____
_____
_____
Has this/these part(s) been injured before? No Yes – When? _____
Were you released the same day? Yes No – How long did you stay? _____
Recommendation/Home Care: _____
Advice to see: Medical Doctor Physical Therapist Chiropractor
Have you seen any other doctor as a result of this accident? No Yes
If yes, who? _____
Diagnosis: _____
Treatment: _____
Have you lost any work because of this? No Yes – Dates: from _____ to _____
Have you been involved in any other accidents? No Yes – How many? _____

Please describe past injuries including dates, types, and treatment received: _____
_____
_____

Please check symptoms you have noticed since this accident:

_ Headache	_ Irritability	_ Hip pain	_ Numbness (arms)
_ Neck pain	_ Chest pain	_ Leg pain	_ Numbness (legs)
_ Stiff neck	_ Dizziness	_ Knee pain	_ Depression
_ Sleep problems	_ Shoulder pain	_ Ankle pain	_ Fatigue
_ Back pain	_ Arm pain	_ Foot pain	_ Lights bother eyes
_ Nervousness	_ Elbow pain	_ Pins & Needles(arms)	_ Loss of balance
_ Loss of Memory	_ Wrist pain	_ Pins & Needles (legs)	_ Fainting
_ Ears Ring	_ Hand pain	_ Shortness of breath	_ Loss of smell/taste
_ Diarrhea	_ Cold feet/hands	_ Upset stomach	_ Fever
_ Constipation	_ Other: _____		

Is there any additional information you would like to provide re: this accident: _____
_____
_____
_____
_____

The medical and accident information I've provided is true and accurate to the best of my knowledge. I also acknowledge and agree to abide by the claims payment policies.

Patient Signature _____ Date_____