Centered in Motion 5125 SW Macadam Ave, Ste 210, Portland, OR 97239 **Phone:** 503.684.9698 **Fax:**503.213.9698

Auto Accident History

Name _____ Date of Birth _____
Your Insurance Co. _____ **Claim #** _____
Insurance Phone # _____ Agent _____ Policy # _____
Have you retained an attorney? ( ) Yes ( ) No Name _____
Were there any witnesses? ( ) Yes ( ) No Name(s) _____

Nature of the accident:
Date of accident _____ Time of day _____
Were you ( ) Driver ( ) Passenger ( ) Front seat ( ) Back seat
Number of people in your vehicle? _____ Other vehicle? _____
What direction were you headed? ( ) North ( ) South ( ) East ( ) West
on (name of street) _____
What direction was the other vehicle headed? ( ) North ( ) South ( ) East ( ) West
on (name of street) _____
Were you struck from ( ) Behind ( ) Front ( ) Left side ( ) Right side
Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long? _____
Were the police notified? ( ) Yes ( ) No
In your own words, please describe the accident: _____
_____
_____
After the accident, you _____
_____

Did you have any physical complaints BEFORE THE ACCIDENT? ( ) Yes ( ) No
If yes, please describe in detail: _____
_____
_____
Please describe how you felt
DURING the accident _____
IMMEDIATELY after _____
LATER THAT DAY _____
THE NEXT DAY _____
What are your PRESENT complaints and symptoms? _____
_____
_____
Do you have any congenital (from birth) factors that relate to this problem? ( ) Yes ( ) No
If yes, please describe: _____
_____

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Do you have any previous illnesses that relate to this problem? ( ) Yes ( ) No

If yes, please describe: _____

_____

Have you ever been involved in an accident before? ( ) Yes ( ) No

If yes, please describe, including the date(s) and type(s) of accidents as well as injuries received: _____

_____

Have you been treated by another doctor since this accident? ( ) Yes ( ) No

If yes, please list doctor's name and contact # _____

What type of treatment did you receive? _____

_____

Since the accident, are your symptoms ( ) improving ( ) same ( ) getting worse

Check any symptoms you have noticed since the accident

□ Headache	□ Irritability	□ Loss of Balance
□ Neck Pain	□ Trouble Concentrating	□ Upset Stomach
□ Mid-back Pain	□ Memory Loss	□ Fatigue
□ Low back Pain	□ Pins and Needles	□ Sleeping Problems
□ Chest Pain	□ Shortness of Breath	□ Cold Hands or Feet
□ Leg Pain	□ Cold Sweats	□ Dizziness
□ Arm Pain	□ Buzzing/ Ringing in Ears	□ Loss of Taste

Have you lost time from work/ school as a result of this accident? ( ) Yes ( ) No

If yes, last day worked _____

Type of employment _____

Are you being compensated for the lost time? ( ) Yes ( ) No

If yes, what type of compensation are you receiving? _____

Do you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No

If yes, please describe in detail: _____

_____

_____

_____

Other pertinent information: _____

_____

_____

_____ _____

Patient signature Date