Dr. Eva Turner 10 East 704th St, Orangeburg NY 10962 845-359-5599

MOTOR VEHICLE ACCIDENT HISTORY

Name _____ Date of Birth _____ Phone _____ Cell _____

Address _____ City _____ State _____ Zip _____

Employer _____ Address _____ Phone _____

Auto Ins. Co. _____ Policy # _____ Agent Name _____ Phone _____

Driver other vehicle _____ Ins. Co. _____ Policy # _____

Attorneys Name _____ Address _____ Phone _____

Witness Name _____ Address _____ Phone _____

Accident Description:

1. Date of accident _____ Time of day _____ City _____ State _____
2. Where were you sitting in the car at the time of the accident? _____

   Were you wearing a seatbelt? ___Yes ___No ____lap belt ___shoulder harness
3. Number of people in your vehicle? _____ Other Vehicle? _____
4. What direction were you headed? _____ Name of street _____
5. What direction was other vehicle headed? _____ Name of street _____
6. Were you struck from ___behind ___front ___left side ___right side
7. Were you knocked unconscious? ___Yes ___No If yes, how long _____
8. Were police notified ___Yes ___No
9. Please describe accident in detail: _____

   _____

   _____
10. Describe any physical complaints prior to the accident. _____

    _____
11. Describe how you felt:

    During the accident: _____

    Immediately after: _____

    Later that day: _____

    The next day: _____
12. Describe your present complaints and symptoms: _____

    _____

13. Were you born with any problems that relate to your present symptoms?_____

_____

14. Describe any previous illnesses that relate to this case:_____

_____

15. Describe any prior accidents/injuries including dates:_____

_____

16. Where were you taken after the accident?_____

17. Have you been treated by any other doctors for this condition? ___Yes ___No

If yes, list doctor's name and address and type of treatment received:_____

_____

18. Since the injury, are your symptoms: ___improving ___getting worse ___the same

19. CHECK SYMPTOMS YOU HAVE HAD SINCE THE ACCIDENT:

___ headache ___irritability ___numbness in toes ___face flushed ___feet cold ___hands cold

___neck pain ___neck stiff ___shortness of breath ___buzzing in ears ___chest pain ___dizziness

___fatigue ___stomach upset ___head too heavy ___loss of balance ___sleeping problems

___fainting ___fever ___depression ___constipation ___back pain ___pins/needles in legs

___light sensitivity ___loss of smell ___cold sweats ___pins/needles in arms ___nervousness

___loss of memory ___loss of taste ___tension ___ fingers numb ___ringing in ears___diarrhea

symptoms other than above_____

20. Any lost time from work as a result of this accident? ___Yes ___No If yes,

Last day worked_____, type of employment_____,

present salary_____, are you being compensated for time lost at work ___Yes ___No

If yes, type of benefits:_____

21. Do you have any activity restrictions as a result of this injury? ___Yes ___No If yes,

describe in detail:_____

22. Additional information:_____

_____

_____ _____

Date Patient signature