The Hixson Spine Center of Chattanooga, Inc.
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Motor Vehicle Accident History Form

Name: _____ **Today's Date:** _____

What date was the motor vehicle accident? _____

Please describe the accident in detail: _____
_____
_____
_____

Vehicles involved:

- Your vehicle Year_____ Make _____ Model_____
- The other vehicle Year_____ Make _____ Model _____

In your own words describe the damage to BOTH vehicles: _____
_____
_____
_____

Accident type: ( ) Rear-end ( ) Head-on ( ) Broad-sided ( ) Don't remember

Please check ALL that apply to your accident:

You were the:	( ) Driver	( ) Passenger
You were sitting:	( ) Front	( ) Back
Did you have the:	( ) seat belt fastened	( ) seat belt unfastened
At the time of the accident, you were:	( ) aware of the collision	( ) unaware of the collision
You were:	( ) braced for the impact	( ) not braced for the impact

Did any part of your body strike anything in the vehicle? ( ) yes ( ) no
If yes, please explain in detail: _____
_____

Did you vehicle have a head rest: ( ) Yes ( ) No

Approximately how high was the top of your head rest in relation to the top of your head?

( ) below your ears ( ) At your ear level ( ) Above your ear level ( ) Not sure

Did your vehicle have air bags and did they deploy?

( ) Yes and Yes ( ) Yes and No ( ) No, do not have air bags

Did your vehicle hit anything else after the impact? ( ) No ( ) Yes, please explain: _____
_____

How fast were the vehicles traveling?

My Vehicle: ( ) Stopped ( ) 1-10 mph ( ) 11-20 mph ( ) 21-30 mph ( ) 31-40 mph ( ) 41-50 mph ( ) 51-above
Other Vehicle: ( ) Stopped ( ) 1-10 mph ( ) 11-20 mph ( ) 21-30 mph ( ) 31-40 mph ( ) 41-50 mph ( ) 51-above

If you were stopped was your foot <u>on</u> the break <u>off</u> of the break? (please circle):

Was your accident reported to the police?	( ) Yes	( ) No
Were any summonses issued?	( ) Yes	( ) No
Is the police report available?	( ) Yes	( ) No
Did you go to the hospital?	( ) Yes	( ) No
Did you get there by Ambulance?	( ) Yes	( ) No
Have you had any other motor vehicle accidents?	( ) Yes	( ) No

What were the weather conditions the day of the accident?

( ) Sunny ( ) Cloudy ( ) Foggy ( ) Light Rain ( ) Heavy Rain ( ) Snowing

Was the Road: ( ) Dry ( ) Wet ( ) Icy ( ) Snowing

The time of day was? ( ) Dawn ( ) Daytime ( ) Dusk ( ) Night

Please list ALL Doctors you have seen for your present condition: _____
_____

Please list ALL Diagnostic testing that was done for your condition. (MRI, X-rays, CAT Scan, etc…):_____
_____

Please list ALL treatments rendered for your condition. (Medicine, Neck or Back Braces, Physical Therapy, etc…): _____
_____
_____

What was the position of your head during the accident?

( ) Straight ahead ( ) Looking in the rear view mirror ( ) Looking to the right ( ) Looking to the left

Did you have any cuts or bruises form the accident: ( ) Yes ( ) No
If yes, please explain in detail: _____
_____

What are your major complaints?

( ) Headaches ( ) Neck Pain ( ) Shoulder Pain, Left or Right ( ) Arm Pain ( ) Leg Pain, Left or Right

If you have an attorney at this time please list his name and number: _____
_____
_____