Today's Date_____ Social Security Number:___-___-_____
Full Name_____
Sex (Check) Male □ Female □ Date of Birth_____
Address:_____
City:_____ State:_____ Zip:_____
Home Phone:_____ Cell:_____
Work:_____ Work Phone:_____
Work Address:_____
City:_____ State:_____ Zip:_____
Supervisor Name:_____
What type of work do you do?_____
Name of Spouse:_____ Phone: _____
Nearest Relative: _____ Phone:_____

DATE OF INJURY/ACCIDENT (required):_____

In your own words, describe the accident:

_____
_____
_____
_____
_____
_____

What was your position in the vehicle? (check one)
□ Driver □ Front Passenger □ Rear Left Passenger □ Rear Right Passenger
□ Other _____
Type of Vehicle:_____
Your speed at the time of the accident:_____ mph
Check all that apply:
□ I was struck by another vehicle □ I hit another vehicle □ I hit a stationary object
Where was your vehicle hit?_____
What type of vehicle hit you?_____
Where you wearing a seatbelt? □ Yes □ No
If yes: □ Full Shoulder and Lap Belt □ Lap Belt Only □ Shoulder Strap Only
Position of Headrest: □ Behind Head □ Behind Neck □ Behind Shoulders □ None
Position of Head: □ Straight Forward □ Turned Right □ Turned Left
Looking: □ Up □ Down
Position of Hands: □ On Steering Wheel □ Other Where:_____
Position of Body: □ Upright □ Turned □ Other Explain:_____

How many people were in the vehicle?_____
Their Names?_____
Were any of the other passengers injured? □ Yes □ No
Were there any casualties in the accident? □ Yes □ No
Were the police called to the accident scene? □ Yes □ No
Was there a police report? □ Yes □ No
Was anyone given a citation at the accident scene? □ Yes □ No
How much damage was done to your vehicle? □ $0-$500 □ $500-$1,000 □ $1,000+
Did your airbags deploy? □ Yes □ No
Were you prepared for the impact? □ Yes □ No
Check one: □ I was completely surprised by the impact
□ I saw the collision coming
□ I saw the collision coming and braced appropriately
What happened to your body at the moment of impact? _____
_____
_____
How did you feel: during the accident_____
immediately after the accident_____
the next day_____
presently_____
Describe your mental/emotional state after the accident:_____
_____
_____
Did you receive medical attention at the accident scene? □ Yes □ No
Did you go to the hospital after the accident? □ Yes □ No Immediately? □ Yes □ No
If no, where did you go?_____
If yes, how did you get there? □ Ambulance □ Drove Yourself □Someone Else Drove
If you did not go to the hospital immediately after the accident, what was the reason for waiting? _____
_____
_____
Name of Hospital: _____
What kind of treatment did you receive? (Check all that apply)
□Bandages □Cast □Neck Brace □Splints □ Collar □Shot
□Medication □X-Rays □Antibiotics □Ice-pack □Hot-pack
□Surgery □Crutches
Please give the name and reason for medication and shots:_____
_____
Have you been seen by any other doctors since the accident? □ Yes □ No
If so, Who?_____

Did any part of your body hit any of the following? (Write in what part of your body hit the car)

□ Dashboard _____ □ Windshield _____
□ Steering Wheel _____ □ Headrest _____
□ Right door _____ □ Left door _____
□ Unknown object _____
Since the accident, have your symptoms: □ Improved □ Worsened □ Stayed the same

Please check any symptoms you have noticed since the accident:

□ Headaches
□ Neck Pain
□ Upper/Mid Back Pain
□ Lower Back Pain
□ Chest Pain
□ Arm Pain/Numbness
□ Hand Pain/Numbness
□ Leg pain/Numbness
□ Foot Pain/Numbness
□ Head Heaviness
□ Neck Stiffness
□ Back Stiffness
□ Pins/Needles in Arms
□ Pins/Needles in Hands
□ Pins/Needles in Legs
□ Pins/Needles in Feet
□ Cold Hands
□ Upset Stomach
□ Diarrhea
□ Constipation
□ Fainting
□ Blurred Vision
□ Ringing in Ears
□ Loss of Balance
□ Loss of Taste
□ Loss of Smell
□ Anxiety
□ Sleeping Problems
□ Tension
□ Irritability

Areas of everyday activity that are or have been affected (please check):

□ Sleeping
□ Eating
□ Bathing
□ Getting Dressed
□ Going to the Bathroom
□ Typing on a keyboard
□ Standing from sitting
□ Standing
□ Walking
□ Sitting
□ Exercise
□ Running
□ Lifting
□Heavy
□Medium
□Light
□ Driving a Car
□ Riding in a Car
□ Vision
□ Feeling
□ Tasting
□ Smelling
□ Emotional Stability
□ Housework

Were you pregnant at the time? □ Yes □ No
Were you recovering from surgery? □ Yes □ No
Before the accident, your lifestyle was: □ Active □ Moderately Active □Inactive
Since the accident, your lifestyle has been: □ Active □ Moderately Active □Inactive
Describe any other physical changes you have noticed: _____
_____
_____
_____

Check the activities you used to do before the accident:

□ Job	□ Volunteer Work	□ Hunting
□ Second Job	□ Exercise	□ Fishing
□ Crafting	□ Dance	□ Yard Work
□ House Work	□ Sports	
□ Sexual Activity	□ Carrying/playing with children	

Explain how your injuries affected your ability to do these activities: _____

_____

_____

_____

_____

INSURANCE

Responsible Party's Insurance

Name: _____ Phone: _____

Address: _____

Policy #_____ Claim #_____

Health Insurance

Name if Insurance Company: _____

Insurance Company Phone #: _____

Policy #_____ Group #_____

Name of Insured: _____

Car Insurance

Name: _____ Adjuster's Name_____

Address: _____

Phone: _____ Policy #_____

Claim #_____

Attorney Information

Attorney Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____

Patient Signature_____ Date: _____

Guarantor (if patient is a minor)_____ Date: _____