

Auto Accident Information

Today's Date: _____ Date of Accident: _____

Patient Name: _____ Home #: _____

Address: _____ City: _____ Zip: _____

Birthdate: _____ Age: _____ Work #: _____

E-mail Address: _____ Cell #: _____

Emergency contact person: _____ Phone: _____

How were you referred to our office? _____

Your Auto Insurance Co: _____ Phone: _____

Policy #: _____ Med Pay Coverage Amount: _____

Claim #: _____ Date you made the claim: _____

Claims Address: _____

Adjuster Name: _____ Phone: _____

Other Party's Name: _____

Address: _____ City: _____ Zip: _____

Birthdate: _____ Home Phone: _____ Cell: _____

Their Auto Insurance Co: _____

Policy #: _____

Claim #: _____ Date they made the claim: _____

Claims Address: _____

Adjuster Name: _____ Phone: _____

Auto Accident History

Patient Name: _____ Phone: _____

Date of Accident: _____ Time: _____

Driver of Car: _____ Who owns the car: _____

Passengers in your car: _____

Year & Model of your car: _____

Year & Model of the other car: _____

Approximate damage to your car= \$ _____ Don't know yet- I'm getting an estimate

Visibility at time of the accident: Poor Fair Good Other _____

Road conditions at the time of the accident: Clear Dark Rainy Wet Icy

Type of accident: Rear-ended You hit the car in front Head-on collision

Broad-side collision (driver side) Broad-side collision (passenger side) Side-swiped

Please describe the accident: _____

Which parts of your head or body hit what parts of the inside of the car: _____

Did you see the accident coming? Yes No Did you brace for impact? Yes No

Were you wearing your seatbelt and shoulder harness at the time of the accident? Yes No

Did the safety airbag inflate during the impact? Yes No

What was the position of those headrests compared to your head before the accident?

- Top of headrest even with the bottom of your head
- Top of headrest even with the middle of your neck
- Top of headrest even with the top of your head
- My car does not come equipped with headrests

Did the police make a report of the accident? Yes No If yes, please give us a copy.

If no, did you exchange information with the other driver? Yes No Hit & Run

As a result of the accident, you were: Shaken and/or shocked that the collision had occurred

Dazed, circumstances vague Rendered almost unconscious Rendered totally unconscious

Could you move all parts of your body after the collision? Yes No

If not, what parts couldn't you move and why? _____

Were you able to get out of the car and walk unaided? Yes No

Did you get any bleeding cuts? Yes No If yes, where? _____

Describe how you felt:

Immediately after the accident: _____

Later that day: _____

The next day: _____

Check any symptoms that you had since the accident:

- | | | |
|--|--|---|
| <input type="checkbox"/> Neck pain/stiffness | <input type="checkbox"/> Headaches | <input type="checkbox"/> Dizziness/Loss of balance |
| <input type="checkbox"/> Midback pain/stiffness | <input type="checkbox"/> Nausea | <input type="checkbox"/> Ringing in the ears |
| <input type="checkbox"/> Lower back pain/stiffness | <input type="checkbox"/> Loss of Sleep | <input type="checkbox"/> Blurred vision |
| <input type="checkbox"/> Numbness in arms/hands | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Numbness in legs/feet | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Loss of senses of taste or smell |
| <input type="checkbox"/> Pain in shoulders | <input type="checkbox"/> Facial Pain | <input type="checkbox"/> Jaw pain / TMJ clicking |
| <input type="checkbox"/> Muscle Tension/Spasms | <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety/Irritability |

Other: _____

Did you get any bruises as a result of the accident? No Yes _____

Your Occupation: _____

Have you missed any time off work? Yes No

Full days off work: _____

Part time off work: _____

When did you go to the hospital or urgent care center to get checked for your injuries? _____

How did you get to that facility? Ambulance Someone drove me there I drove myself there

Name of Hospital: _____ Location: _____

What treatment did you receive? _____

Did they do any special tests? X-Rays MRI CT Scan Blood

What other doctors have you seen for these injuries (besides at this office)?

Dr. Name: _____ Date: _____

What treatment did you receive? _____

Did they do any special tests? X-Rays MRI CT Scan Blood

Any Other Doctors Seen: _____

Please list all medications you are presently taking, what they are for and how often you take them:

1. _____

2. _____

3. _____

Neck Pain: _____

Describe how the neck pain feels: Sharp Dull Soreness Throbbing

Do you feel: Stiffness Swelling Headaches Numbness/Tingling in Arms/Hands

How often does the neck pain occur: Constant Intermittent _____

Is the neck pain: Improving Getting worse Staying the same

On a scale of 1-10, rate the severity of your neck pain:

(no pain) 1 2 3 4 5 6 7 8 9 10 (most severe)

What activities make the neck pain worse? _____

Does the neck pain interfere with your: Work Sleep Exercise Daily activities

Mid Back Pain: _____

Describe how the midback pain feels: Sharp Dull Soreness Throbbing

Do you feel: Stiffness Swelling Cramping Radiation of Pain _____

Is the pain: Improving Getting worse Staying the same Constant Intermittent

On a scale of 1-10, rate the severity of your midback pain:

(no pain) 1 2 3 4 5 6 7 8 9 10 (most severe)

What activities make the midback pain worse? _____

Does the midback pain interfere with your: Work Sleep Exercise Daily activities

Lower Back Pain: _____

Describe how the lower back pain feels: Sharp Dull Soreness Throbbing

Do you feel: Stiffness Swelling Cramping Burning Shooting/Shocking

Radiation of pain _____ Numbness/Tingling _____

Is the pain: Improving Getting worse Staying the same Constant Intermittent

On a scale of 1-10, rate the severity of your lower back pain:

(no pain) 1 2 3 4 5 6 7 8 9 10 (most severe)

What activities make the lower back pain worse? _____

Does the low back pain interfere with your: Work Sleep Exercise Daily activities

Other Complaint Area: _____

Describe how the pain feels: Sharp Dull Soreness Throbbing

Do you feel: Stiffness Swelling Cramping Other _____

Is the pain: Improving Getting worse Staying the same Constant Intermittent

On a scale of 1-10 (1 least, 10 most), rate the severity of the pain: _____

What activities make the pain worse? _____

Does the pain interfere with your: Work Sleep Exercise Daily activities

Do you have any other complaints that are related to this accident? If so, please describe:

Prior to this accident, have you ever had any of the physical complaints similar to what you have now?

Yes No Don't Know If yes, please describe: _____

Were these similar complaints the results of a previous accident? Yes No Don't Know

If yes, please describe details of the accident: _____

Have you had any other serious accidents that required medical care? Yes No

Describe: _____

Have you had any serious illnesses that required hospitalization? Yes No

Describe: _____

Have you had any surgeries/broken bones? Yes No _____

List type of surgery and date: _____

Have you ever been diagnosed with any of these conditions:

Cancer Type: _____ Treatment: _____

Diabetes Type: _____ Treatment: _____

Heart Problem: _____ Treatment: _____

High Blood Pressure- Last reading: _____

Stroke Seizures Chest Pain Other _____

Asthma _____ Allergies _____

Digestive Problems _____ Heartburn Gas/Bloating Constipation/Diarrhea

Recent Illness _____ Fever Nausea/Vomiting Dizziness

Head injuries Concussion Knocked unconscious _____

Spinal Arthritis Disc Herniation Epidural Injection _____

Any other spinal problems: _____

Are you pregnant? Yes No Maybe- my last period was: _____

How would you like to pay for your care? Cash/check Credit Card Insurance

Do you have an attorney representing you for this accident? _____

Address: _____ City: _____ Zip: _____

Phone: _____ Fax: _____

The above is accurate to the best of my knowledge

Signature

Print Name

Date