ACCIDENT INFORMATION

Patient Name:________________________
Today's Date:_______ Date of Accident:__________
Time of Accident:__________☐ a.m. ☐p.m.
Police report made? ☐ Yes ☐ No
Were you: ☐ Driver ☐ Front Passenger ☐ Rear Passenger
If a traffic violation was issued, to whom was it issued?________________________
Were you struck from: ☐ Behind ☐ Right ☐ Left ☐ Front
Number of people in accident vehicle__________
Location/street on which you were traveling (cross streets & direction):________________________
Accident description:________________________
____
____
____

Were you wearing your seat belt? ☐ Yes ☐ No
Was this vehicle equipped with airbags? ☐ Yes ☐ No
If yes, did they inflate? ☐ Yes ☐ No
What did your vehicle impact? ☐ vehicle ☐ Other
If other, explain:________________________
Did you strike anything in the vehicle? ☐ Yes ☐ No
If yes, please describe:________________________
Make & model of the vehicle you were occupying?
____
Make and model of other vehicle?
____
What was the approx. speed of your vehicle?_______
Approx. speed of other vehicle?__________
During impact, were you facing:
☐ Forward ☐ Right ☐ Left
Were you ☐ aware of ☐ surprised by the impact?
Did accident render you unconscious? ☐ Yes ☐ No
If yes, for how long?________________________
Please describe how you felt immediately after the accident?________________________
____
____

Have you gone to a Hospital or seen any other Doctor?
☐ Yes ☐ No ☐ Emergency room only
When did you go?
☐ Just after accident ☐ next day ☐ 2 days plus
How did you get there?
☐ ambulance ☐ private transportation
Name of hospital and/or Attending doctor:
____
Describe any treatment you received:__________
____
____

Were X-rays taken? ☐ Yes ☐ No
Was medication prescribed? ☐ Yes ☐ No
If yes, list meds ________________________
____
____

Have you been able to work since injury? ☐ Yes ☐ No
Number of days lost from work__________
Date disability (time loss) began__________
Date returned to work__________

INDICATE SYMPTOMS THAT ARE A RESULT OF ACCIDENT:

☐ Dizziness	☐ Lower back Pain	☐ Neck Pain
☐ Memory Loss	☐ Arms/Shoulder Pain	☐ Neck Stiffness
☐ Headaches(s)	☐ Numb Hands/Fingers	☐ Back Pain
☐ Blurred vision	☐ Numb Feet/Toes	☐ Back Stiffness
☐ Nausea	☐ Shortness of Breath	☐ Leg Pain
☐ Depression	☐ Stomach Upset	☐ Jaw Pain
☐ Irritability	☐ Trouble sleeping	☐ Chest Pain
☐ Tension	☐ Ringing in Ear	☐ Fatigue

Other complaints not described above__________
____
____

Is your condition getting worse? ☐ Yes ☐ No
Is your condition ☐ Constant ☐ Comes and goes

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable	Painful
Lying on back	☐	☐	☐
Lying on side	☐	☐	☐
Lying on stomach	☐	☐	☐
Sitting	☐	☐	☐
Standing	☐	☐	☐
Stretching	☐	☐	☐
Lovemaking	☐	☐	☐
Walking	☐	☐	☐
Running	☐	☐	☐
Sports	☐	☐	☐
Working	☐	☐	☐
Lifting	☐	☐	☐
Bending	☐	☐	☐
Kneeling	☐	☐	☐
Pulling	☐	☐	☐
Reaching	☐	☐	☐

Insurance Information

Your Auto Ins. Co.________________________
Address:________________________
____
Policy &/or Claim #:________________________
Agent & Phone #: ________________________

Name of other Party:________________________
Their Ins. Co.________________________
Address:________________________
____
Policy &/or Claim #:________________________
Agent & Phone #:________________________

ATTORNEY:
Name________________________
Address:________________________
____
Phone:________________________

Patient Signature________________________

Pain Chart

Name:____________________________________

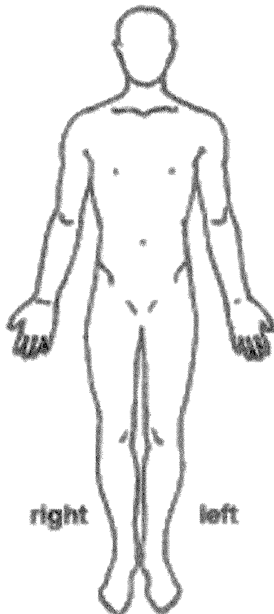
Date:_____________________________________

Weight:__________lbs. Height:____Ft. _____in.

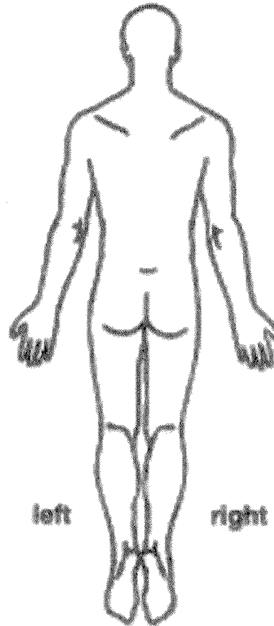
Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Include all affected areas. Indicate the degree of pain using a scale from 1 (minimal discomfort) to 10 (extreme pain).

Numbness	Pins & Needles	Burning	Aching	Stabbing
-----	OOOOO	ΛΛΛΛΛ	XXXXX	/////

Right



Front



Back

Left

How did your condition begin?____

____

____

____

When did your condition begin?________________________________

Is this condition getting worse? yes ____ No ____ Constant _____ Comes and goes ______

What makes your condition better/what makes it worse?______________________________________

____