Auto Accident History

Name _____ Today's Date ___/___/___ Date of Birth ___/___/___

Sex: M F Marital Status: S M D W Occupation _____ Employer _____

Address _____ City _____ State ____ Zip _____

Cell Phone (____) _____ Work Phone (____) _____ Home Phone (____) _____

Email Address _____ may we send you newsletters or office information by email? Y N

May we text you appointment reminders? Y N

Emergency Contact _____ Phone (____) _____

Primary Care Doctor _____ Phone (____) _____ may we contact them? Y N

Your Auto Insurance Company _____ Phone (____) _____

Name of Agent and/or Adjustor _____ Claim #_____

Do you have an Attorney? Y N Name _____ Phone (____) _____

3rd Party Auto Insurance Company_____ Phone (____) _____

Name of Agent and/or Adjustor _____ Claim #_____

Internal Office Use

Claim # verified Y N

Adjustor Name:

Adjustor Phone:

Claims Mailing Address:

List all drugs (prescription and over the counter) and nutritional supplements you are taking:

Name	Purpose	Dosage
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List any known allergies _____

ACCIDENT HISTORY:

Date of Accident ___/___/___ Time of Accident _____ am/pm City of Accident _____ State ___

Did the police arrive? Y N Please bring us a copy of the accident report.

State how the accident happened _____

_____

What type of vehicle were you in? Make _____ Model _____

Were you driving? Y N Was it your car? Y N If not, whose car was it? _____

Were you passenger? Y N Were you rotated in your seat? Y N

Were other people in the car? Y N Names, phone numbers _____

Were you wearing your seat belt? Y N Shoulder harness on? Y N Headrest: high or low

What were the weather conditions? _____ Traffic Conditions?_____

Type of road: single lane highway/freeway gravel road

Did it happen at a: stop sign traffic light intersection on road

Did your vehicle hit something? Y N If yes: another car sign/pole tree bridge embankment

Did your vehicle go off the road? Y N If yes: into ditch into embankment How Deep? _____

In what condition was the vehicle prior to the accident? _____

What was the damage to the vehicle?

Inside _____ Outside _____

If there was another vehicle involved, was it a: car truck motorcycle Other _____

What was the damage to the other vehicle?

Inside _____ Outside _____

Do you have pictures of the automobile? Y N

Was an accident report made? Y N Police of City _____ County_____

Who was at fault? _____

Have you had any time loss from work? Y N If yes, from _____ to _____

SYMPTOMS:

Did you hit your head, arm, chest, leg, etc? Explain _____

_____

Were you conscious after accident? Y N Do you remember the impact? Y N

Did you go to the hospital after the accident? _____

Names of any treating Doctors since accident _____

What care were you given since accident? _____

How did you feel after the accident? Where was the pain? _____

Does it bother you to ride in a car now as passenger or driver? Y N

BELOW: list your symptoms, from <u>most severe</u> to <u>mildest</u>, and include ANY and ALL areas that bother you including knees, shoulders, hands, feet, ear infections, headaches, jaw, etc.

Worst symptom:_____ What happened?_____

Severity of pain: 0 1 2 3 4 5 6 7 8 9 10 When did the pain start? _____

Quality of pain (circle all that apply): sharp shooting dull ache burning stabbing stiff throbbing numbness

Does your pain radiate into arms? Y N Legs? Y N

Worse with (circle all that apply): sitting standing walking bending lifting other:_____

Better with (circle all that apply): rest ice heat stretching exercise pain relievers topical creams other:_____

Worse during (circle): morning afternoon evening during sleep

What treatment have you received for this condition (circle): medication physical therapy surgery other:_____

List any area of your life affected by this complaint (ex: work, home, kids, hobbies, etc) 1. _____

2. _____

3. _____

Symptom 2:_____ What happened?_____

Severity of pain: 0 1 2 3 4 5 6 7 8 9 10 When did the pain start? _____

Quality of pain (circle all that apply): sharp shooting dull ache burning stabbing stiff throbbing numbness

Does your pain radiate into arms? Y N Legs? Y N

Worse with (circle all that apply): sitting standing walking bending lifting other:_____

Better with (circle all that apply): rest ice heat stretching exercise pain relievers topical creams other:_____

Worse during (circle): morning afternoon evening during sleep

What treatment have you received for this condition (circle): medication physical therapy surgery other:_____

List any area of your life affected by this complaint (ex: work, home, kids, hobbies, etc) 1. _____

2. _____

3. _____

Symptom 3:_____ What happened?_____

Severity of pain: 0 1 2 3 4 5 6 7 8 9 10 When did the pain start? _____

Quality of pain (circle all that apply): sharp shooting dull ache burning stabbing stiff throbbing numbness

Does your pain radiate into arms? Y N Legs? Y N

Worse with (circle all that apply): sitting standing walking bending lifting other:_____

Better with (circle all that apply): rest ice heat stretching exercise pain relievers topical creams other:_____

Worse during (circle): morning afternoon evening during sleep

What treatment have you received for this condition (circle): medication physical therapy surgery other:_____

List any area of your life affected by this complaint (ex: work, home, kids, hobbies, etc) 1. _____

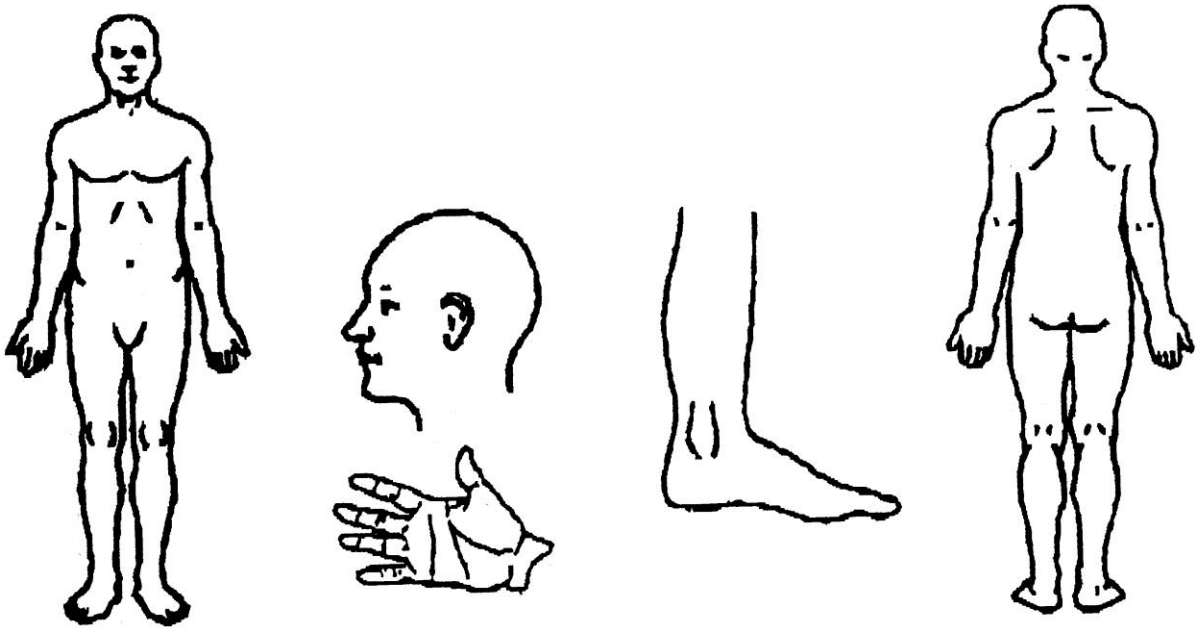
2. _____

3. _____

INJURY DETAIL:

Please circle area(s) of injury and describe your symptoms using the codes listed below.

N - Numbness P - Pain T – Tingling A – Ache S – Soreness ST – Stiffness MSP – Muscle Spasm



I attest that the above given information is complete and accurate to the best of my knowledge.

Signature _____ Date _____