Patient Information

First Name:_____M.I.___Last Name_____ID#_____
Sex:___ D.O.B._____ Social Security Number_____-_____-_____
Address_____
City_____State_____Zip_____Cell (_____) _____-_____

Insurance
Insurance Carrier _____
Address_____City_____State_____
Zip_____Policy/ Claim #_____Phone(_____)____-_____

Employer
Current Employer _____
Address_____City_____State_____
Zip_____Group #_____ Phone (_____)_____-_____

Date of Injury_____/_____/_____
Time of Injury_____:_____am ____pm
Date of 1st Tx_____/_____/_____

Attorney Information:
_____
_____
_____

Is this injury a:
____ Auto Accident ____ Work Comp Injury _____Slip/Fall _____Other

Previous Treatment and Conditions_____
_____
_____
_____
_____
_____

History of Onset (injury)_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Auto Accident Injury Information

What was your position in the vehicle?

( ) The driver **( )** The rear passenger
( ) The front passenger **( )** A pedestrian **( )** Other: _____

What type of vehicle were you driving?

( ) Compact car **( )** Full size car **( )** Full size truck **( )** Full size van
( ) Mid size car **( )** Compact truck **( )** Mini van **( )** Compact sport utility vehicle
( ) Full size sport utility vehicle **( )** Motorhome
( ) Motorcycle **( )** Bicycle **( )** Other: _____

What speed were you traveling at the time of the accident?

( ) Stopped at a stop light **( )** At a complete stop
( ) Slowing down at an intersection **( )** Moving slowly
( ) Traveling at approximately ___ mph **( )** Merging into traffic
( ) Traveling faster than 65 mph **( )** Other: _____

Who hit whom?

( ) Was struck by another vehicle **( )** Struck a stationary object
( ) Struck another vehicle **( )** Other: _____

What was your vehicle's point of impact?

( ) On the front **( )** On the left front **( )** On the rear **( )** On the left rear
( ) On the right front **( )** On the middle front **( )** On the right rear **( )** The middle rear
( ) On the right side **( )** On the rear right side **( )** **On** the left side
( ) On the front right side **( )** On the middle right side **( )** **On** the front left side
( ) On the rear left side **( )** On the middle left side **( )** Other: _____

What speed was the other vehicle traveling?

( ) Stopped at a stop light **( )** At a complete stop
( ) Slowing down for an intersection **( )** Moving slowly
( ) Merging into traffic **( )** **Traveling** faster than 65 mph
( ) Traveling at approximately ___ mph **( )** Other: _____

What was the other vehicle's point of impact?

( ) On the front **( )** On the left front **( )** On the rear
( ) On the right front **( )** On the middle front **( )** On the right rear
( ) On the left rear **( )** On the right side **( )** On the rear right side
( ) On the middle rear **( )** On the front right side **( )** On the middle right side

( ) On the left side **( )** On the rear left side
( ) On the front left side **( )** On the middle left side **( )** Other: _____

Were you wearing seat restraints?

( ) Was wearing a full lap and shoulder restraint
( ) Was wearing a shoulder restraint **( )** Was wearing a lap restraint
( ) Was not wearing any seat restraints **( )** Other: _____

What position were your vehicle head rests in?

( ) Did have a head rest which was adjusted in the lowest position
( ) Did have a head rest which was adjusted in the middle position
( ) Did have a head rest which was adjusted in the highest position
( ) Was not equipped with a head rest
( ) Other: _____

Did your air bag deploy?

( ) Air bags were deployed **( )** Other:_____
( ) Air bags were not deployed

Were you prepared for the impact?

( ) Was completely surprised by the accident
( ) Saw the collision coming and braced appropriately
( ) Saw the collision coming **( )** Other: _____

What position was your body in just prior to impact?

( ) A straight position **( )** A position rotated to the left
( ) A tilted forward position **( )** A position rotated to the right
( ) A position that cannot be remembered
( ) Other: _____

What happened to your body the moment of impact?

( ) Body was tensed for impact **( )** Body violently torqued and twisted
( ) Body whipped violently forward and backward
( ) Body was thrown over the seat **( )** Body was thrown from the vehicle
( ) Body was thrown violently from side to side
( ) Body was pinned in the vehicle **( )** Body was badly cut and bruised
( ) Other: _____

What was your mental/emotional state immediately following the accident?

( ) Was not rendered unconscious by the impact of the accident
( ) Was not rendered unconscious but was shaken and disoriented
( ) Was not rendered unconscious but was shaken up
( ) Was not rendered unconscious but was disoriented
( ) Was rendered unconscious by the impact of the accident
( ) Other: _____

Did you receive medical attention at the scene of the accident?

( ) Did receive medical attention
( ) Did not receive medical attention **( )** Other: _____

Where did you go immediately following the accident?

( ) Was taken to the hospital
( ) Was taken home
( ) Resumed activities
( ) Was taken to a personal physician
( ) Was taken to this office
( ) Other: _____

List each of your body parts that struck the following vehicle parts during the accident (Not all may apply).

Dashboard:
Which body part(s)?_____

Windshield:
Which body part(s)?_____

Steering Wheel:
Which body part(s)?_____

Right Door:
Which body part(s)?_____

Left Door:
Which body part(s)?_____

Seat Frame:
Which body part(s)?_____

Unknown Object:
Which body part(s)?_____

Have you had spinal X-rays, MRI or CT Scan?
□No

□Yes, Date(s) and place taken_____

_____

Please check all of the following that apply to you or check:

□ **NONE APPLY**

NO	YES		NO	YES	
□	□	History of recent Infection	□	□	Recent Trauma
□	□	Recent Fever	□	□	Prostrate Problems
□	□	HIV / AIDS	□	□	Frequent Urination
□	□	Diabetes	□	□	Pregnancy, # of Births:_____
□	□	Corticosteroid Use	□	□	Abnormal Weight Gain/Loss
□	□	Birth Control, Type:_____	□	□	Epilepsy / Seizures
□	□	High Blood Pressure	□	□	Visual Disturbances
□	□	Stroke, Date:_____	□	□	History of low/mid back pain
□	□	Dizziness / Fainting	□	□	History of neck pain
□	□	Numbness in Groin / Buttocks	□	□	Arthritis
□	□	Urinary Retention	□	□	History of alcohol use
□	□	Aortic Aneurysm	□	□	History of tobacco use
□	□	Cancer / Tumor	□	□	Surgeries / Medications:____
□	□	Osteoporosis			_____
					_____

Does your family have a history of any of the following?
□ Cancer □ Diabetes □ High Blood Pressure □ Cardiovascular Problems / Strokes

I certify that the above information is complete and accurate to the best of my knowledge. If the health plan is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered. I agree to keep all information up to date, and to notify this doctor immediately of any changes in my health condition or health plan as they occur.

Patient Signature:_____ **Date:**_____

AUTO ACCIDENT INFORMATION SHEET

Patient's Name:_____

Home Telephone: _____Cellular Telephone:_____

Patient's Address:_____

City, State, Zip Code:_____

Date of Injury:_____Initial Date:_____

Social Security:_____Date of Birth:_____

Attorney Name:_____

Attorney Phone:_____Attorney Fax:_____

Insurance Name:_____

Insurance Address:_____

City, State, Zip Code:_____

_____

EMPLOYER'S INFORMATION

Employer's Name:_____

Employer's Telephone(s):_____

Address:_____

City, State, Zip Code:_____