

-- Auto Accident Information --

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Please complete this packet as completely and as accurately as your current condition allows. Where response choices are required, please use a check mark “√” to indicate the most appropriate answer. If a question does not apply to you, please write “N/A” (not applicable). If you are unsure about how to accurately answer a question, write a “?” next to it. Please PRINT all responses and ask for assistance if you have any questions.

Patient's Name: _____ Today's Date: _____ Date of Injury: _____
Age: _____ Date of Birth: _____ Gender: M F Marital Status: _____ SS#: _____
Street Address: _____ City: _____ State: _____ Zip: _____
Home Phone: (____) _____ Mobile Phone: (____) _____ Email Address: _____
Emergency Contact Name: _____ Emergency Phone: (____) _____
Occupation: _____ Employer: _____
Employer's Address: _____ Work Phone: _____

At the time of the collision, who was driving the vehicle you were in? I was The person indicated below was driving:
(Do Not Complete This Section If **You** Were the Driver) Driver's Name: _____
Driver's Address: _____ Driver's Phone: (____) _____

Was the vehicle registered to you? Yes No If not, who was it registered to? _____

Your seating position in the vehicle: Front Seat Back Seat / Left Right Center _____

Was anyone else in the vehicle with you at the time of the collision? Yes No If yes, identify all persons below:

	Name	Relationship	Age	Injured?		
1.	_____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
2.	_____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
3.	_____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
4.	_____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure

Were you on the job at the time of the collision? Yes No If yes, was it reported to your employer? Yes No

Location of the accident: _____

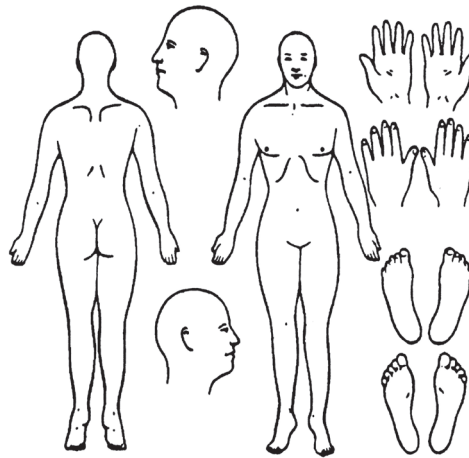
What were the road and weather conditions like at the time? _____

Please describe, in detail, how the accident happened: _____

Please diagram the accident below:	Total number of vehicles involved in the collision: _____
	Total number of impacts to your vehicle: _____
	Side(s) of your vehicle impacted: _____
	Were you wearing a lap & shoulder belt? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Was there a head restraint? <input type="checkbox"/> Yes <input type="checkbox"/> No
	At impact, was head forward of head restraint? <input type="checkbox"/> Yes <input type="checkbox"/> No
	At impact, was your head rotated? <input type="checkbox"/> Yes <input type="checkbox"/> No
	At impact, was your torso rotated? <input type="checkbox"/> Yes <input type="checkbox"/> No
	At impact, was your body leaning forward? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Did you anticipate the impact? <input type="checkbox"/> Yes <input type="checkbox"/> No
Estimated speed of YOUR vehicle at impact: _____ mph	
Estimated speed of OTHER vehicle at impact: _____ mph	

Did you strike anything within the vehicle? Yes No If yes, please identify the item struck in the vehicle from the list below. Also, please draw a line from the item impacted to the part of the body struck.

- Airbag
- Dashboard
- Windshield
- Steering wheel
- Gear selector
- Head restraint
- Inner door panel
- Ceiling
- Armrest
- _____
- _____



Comments

Did the seat you were in break and/or fall backwards from the impact? Yes No Explain: _____

Did any windows break in your vehicle? Yes No If yes, please identify: _____

Was there any "flying" glass from the impact? Yes No If yes, please identify: _____

Were there any: Cuts? Yes No / Bruises? Yes No / Abrasions? Yes No / Photos taken? Yes No

If yes, please describe: _____

Make and model of the vehicle you were in: _____ Year: _____

Describe any damage done to the vehicle you were in: _____

Photos taken? Yes No

Make and model of the other vehicle(s): _____ Year: _____

Describe any damage done to the other vehicle(s): _____

Photos taken? Yes No

After impact, did you: lose consciousness at any time? Yes No _____

lose bowel or bladder control? Yes No _____

have facial numbness/speech problems? Yes No _____

extremity numbness/weakness? Yes No _____

Were you able to get out of the vehicle on your own? Yes No If not, who helped you? _____

If you were assisted out of your vehicle, describe how you were removed: _____

Did you receive any first aid at the scene? Yes No If yes, by whom? _____

If applicable, what first aid was provided to you at the scene? _____

Who was called or came to the accident scene? Highway Patrol Local Police Sheriff Paramedics

Ambulance Other _____

Was a report made? Yes No If yes, do you have a copy? Yes No Not yet, but I will provide it.

Did you go to the emergency room? Yes No Urgent care? Yes No Doctor's office? Yes No
If you answered "yes" to any of the above questions, please identify where you went and who attended you there: _____

What was done for you there? Exam: Yes No Pain medication: Yes No
X-ray: Yes No Anti-inflammatories: Yes No
MRI: Yes No Muscle relaxants: Yes No
CT: Yes No Supports/Braces: Yes No

What diagnoses were you given? _____

Were you told to do anything by the attending doctor? Yes No If yes, please identify: _____

Were you hospitalized at any time as a result of the injuries you sustained from the accident? Yes No If yes, please identify the name and location of the hospital, entry date, exit date, and the name of the treating doctor(s): _____

What was done for you at the hospital? _____

Describe symptoms: Immediately after the accident: _____

Later that same day: _____

The next day: _____

Have you seen any other health care professional since the first day of the accident? Yes No If yes, please complete the section below: *(Begin with the person you saw first and proceed to the most recent.)*

Name	Title	Dates seen	What was done for you?

Please identify any other treatment for this injury (check all that apply): *(specify)*

- Heat Slept in different position Restricted home activities: _____
- Cold Slept on a different surface _____
- Rest Minimized motions of the head Restricted work activities: _____
- Exercise Minimized overhead work _____
- Stretches Minimized lifting Continued prescription meds: _____
- Massage Minimized sitting Took over-the-counter meds: _____
- Other: _____

Normal job duties: _____

Current job duties: _____

Have you missed any work and/or job opportunities as a result of your auto accident? Yes No Please identify: _____

Have you had any injury or significant illness *since* the auto injury? Yes No If yes, please describe: _____

Have you had any significant injury or illness, of any type, *prior* to the auto injury? Yes No If yes, what was the nature of the problem and when did it occur? _____

If professional care was rendered for the above prior injury or condition, how long were you treated, by whom, and what was done for you? Was it fully resolved? _____

Have you ever had any award of permanent disability/impairment for any prior condition/injury? Yes No If yes, please identify what the award was, when it was received, and for what condition/injury: _____

Are you currently under any other doctor's care? Yes No If yes, who is the doctor and what is he/she treating you for? _____

What medications, prescribed or not, are you currently taking to treat any condition or injury *unrelated* to your auto accident injuries? _____

Have you ever served in the armed forces? Yes No If yes, what were the dates of service and what type of discharge did you receive? _____

Prior to this auto accident, have you ever been diagnosed as having any of the following? Circle *all* that apply.

- | | | | | |
|--------------|-----------------|-------------------|-----------------------|---------------------------|
| Whiplash | Neck Sprain | Spondylolysis | Vertebral Fracture | Rheumatoid Arthritis |
| Scoliosis | Back Sprain | Facet Arthrosis | Metabolic Disorder | Ankylosing Spondylitis |
| Spondylosis | Osteoporosis | Disc Protrusion | Diabetes Type 1 or 2 | Foraminal Encroachment |
| Fibromyalgia | Pagets Disease | Spinal Infection | Any Spinal Anomaly | Carpal Tunnel Syndrome |
| TMJ Problem | Spinal Stenosis | Spondylolisthesis | Extremity Dislocation | Degenerative Disc Disease |

Comments: _____

Before the auto accident, how would you rate your overall health? Excellent Good Fair Poor

Do you currently use tobacco products? Yes No If yes, how much do you smoke per day? _____

Do you currently drink alcohol? Yes No If yes, how much and how often? _____

Did you have any recreational activities or hobbies before the accident? Yes No If yes, what were they and how often did you do them? _____

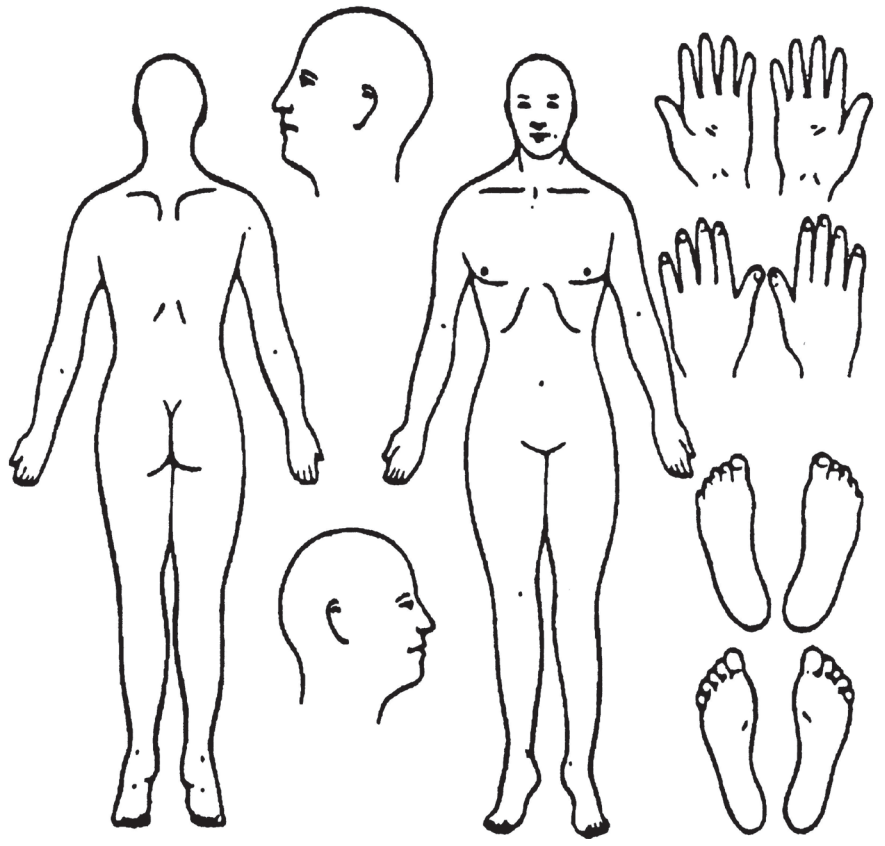
Please provide any additional information you believe is important to your case: _____

Current Medical Complaints

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It is important to carefully identify your current complaints. Use the body diagram to identify the location and nature of your symptoms. **Please use the key below.**

- +++ = sharp or stabbing
- ~ = burning
- ooo = pins and needles
- vvv = dull or aching
- /// = numbness



-- Comments --

--- Circle the number of any and all symptoms that have appeared, even briefly, since the time of the auto collision.---

- | | | |
|---|---|---|
| <ul style="list-style-type: none"> 1. Nausea 2. Vertigo/dizziness/lightheadedness 3. Neck pain/stiffness 4. Headache 5. Photophobia (sensitivity to light) 6. Phonophobia (sensitivity to loud noises) 7. Tinnitus (ringing in the ears) 8. Impaired memory 9. Difficulty concentrating 10. Impaired comprehension or awareness 11. Prolonged, unexplained staring 12. A feeling of having a "brain fog" 13. Forgetfulness 14. Impaired logical thinking 15. Difficulty with new or abstract concepts 16. Insomnia (difficulty sleeping) 17. Fatigue 18. Apathy 19. Outburst of anger 20. Mood swings 21. Depression 22. Loss of libido (sex drive) 23. Personality change 24. Intolerance to alcohol | <ul style="list-style-type: none"> 25. Clicking in the jaw 26. Popping in the jaw 27. Locking of the jaw 28. Side shift of the jaw upon opening 29. Inability to open the mouth wide 30. Pain on chewing 31. Facial pain 32. Grinding your teeth 33. Jaw muscles sore upon waking 34. Chewing on one side of your mouth 35. Painful teeth 36. Loose or chipped teeth 37. Tender muscles in front of the neck | <ul style="list-style-type: none"> 47. Loss of weight 48. Weight gain 49. Nightmares 50. Pain on inhaling deeply 51. Indigestion 52. Diarrhea 53. Constipation 54. Vomiting 55. Nervousness 56. Cramping 57. Knees buckling unexpectedly 58. Dropping things easily 59. Weakness in the arms or legs |
|---|---|---|
- Other Symptoms and/or Comments:*

Please sign and date this 5-page form here: **Signature:** _____ **Date:** _____