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AUTO ACCIDENT PERSONAL INJURY FORM

SECTION A.

Name _____ Date of Birth _____

Home Phone _____ Cell Phone _____

Address _____ City _____ State _____

Zip _____ Social Security Number _____

Your Insurance Company _____

Insurance Company's Phone _____

Policy Number_____ Claim Number_____

Were there any witnesses? ( ) Yes ( ) No

Name (s) _____

NATURE OF ACCIDENT:

1. Date of Accident _____Time of day_____
2. Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat
3. Were you struck from: ( ) Behind ( ) Front ( ) Left ( ) Right
4. Were police notified? ( ) Yes ( ) No
   Was there a police report? ( ) Yes ( ) No

SECTION B:

Description of Accident (CHECK or CIRCLE all appropriate descriptions)

_____Stopped/slowing down for (traffic/red light/stop sign) and was struck in the rear by another vehicle.

_____Pushed into the vehicle in front of mine.

_____Slowing down to execute a turn and was struck in the rear by another vehicle.

_____Another vehicle traveling in the opposite direction collided head-on with the vehicle in which you were riding.

_____Another vehicle ran a (red light/stop sign) and struck your vehicle (broadside/in the rear/in the front end). Driver's side Passenger's side

_____The vehicle in which you were riding was struck by another vehicle causing it to (spin around/roll over).

_____There were more than 2 vehicles involved in this collision.

Describe: _____

_____You were involved in a motor vehicle collision.

Type of vehicles, model, and year:

Patient's:_____

Other Driver's:_____

Amount of damage:_____

Road Conditions:

_____ Rain _____ Ice _____ Snow _____ Dry

_____ Day _____ Night

_____ The driver of the vehicle in which you were (riding/driving) lost control and (struck another vehicle/ran off the road/struck an object- describe:_____ _____).

_____ You were thrown from the car to the pavement.

_____ You were a pedestrian and were struck by a motor vehicle.

_____ Other (brief description):_____ _____

Were you wearing a Seat belt? ( ) Yes ( ) No

Harness? ( ) Yes ( ) No

Lap Belt? ( ) Yes ( ) No

Were your brakes ( ) On ( ) Off ?

Did you strike any object inside the car? ( ) Yes ( ) No

Select from the following (any parts of your body struck at the point of impact):

_____ Head _____ Face _____ Chest _____ Neck _____ Back

_____ Shoulder (s) Rt/Lt _____ Arm (s) Rt/Lt _____ Leg (s) Rt/Lt

_____ Knee (s) Rt/Lt Other:_____

Select the objects that struck the body parts:

_____ Windshield _____Back of Seat _____ Headrest

_____ Seat Broke _____Dash Board _____ Jarred or thrown about

_____ Steering column _____ Door Frame _____ Rear view window

_____ Cannot remember details (dazed) _____ Rendered unconscious

_____ Other: _____

Were you: _____ Unconscious / How Long? _____

_____ Cut or bleeding – describe: _____

_____ Neither

Were you aware of the pending impact? ( ) Yes ( ) No

Did you brace for the impact? ( ) Yes ( ) No

Which direction were you looking at the time of impact?

( ) Right ( ) Left ( ) Up ( ) Down ( ) Straight ahead

If applicable, indicate any pains or abnormal sensations experienced by you immediately following impact:

_____ Felt no immediate pain _____ Headaches

_____ Pain began several hours after accident _____ Saw stars

_____ Semi-conscious state _____ Mid back pain – Rt/Lt

_____ Low back pain – Rt/Lt _____ Upper extremity pain – Rt/Lt

_____ Lower extremity pain – Rt/Lt _____ Neck pain – Rt/Lt

_____ Other:_____

Indicate any actions taken by yourself immediately following the accident:

_____ Went home and took it easy

_____ Went about normal business

_____ Went to physician

_____ Went to hospital

_____ You doctored yourself thinking pain would go away(Over the counter products)

_____ Pain began later that day/night

_____ Pain began the next day

HOSPITALIZATION

Indicate method of delivery to hospital:

_____ Ambulance _____ You drove yourself

_____ Driven by spouse/relative/friend/employer

_____ Went home and taken later or drove yourself

Name of hospital: _____ City _____

Were you seen in the emergency room? ( ) Yes ( ) No

Were you admitted to the hospital? ( ) Yes ( ) No

If yes, length of stay: _____

Name (if known) of admitting physician: _____

Indicate any procedures performed at the hospital (including ER)

_____ Examination _____ Stitches

_____ X-Rays _____ Physiotherapy

_____ Prescriptions _____ Cervical collar

_____ Injection _____ Wounds dressed

_____ Complete bed rest _____ Other: _____

What did you do after your release from the hospital?

_____ Returned home and took it easy

_____ Returned home and went to bed

_____ Returned home and returned to ER after _____ hours/days

_____ Returned to work

When did you first consult a physician?

_____ Same day _____ Following day _____ Within a few days

Other: _____

**** If you consulted this office first, skip to Past History****

Who was the first physician you consulted? Dr._____

_____ Family physician _____ Chiropractor _____ Osteopath

_____ Orthopedist _____ Neurologist _____ Family walk-in clinic

_____ Other: _____

What was done?

_____ Examined	_____ Collar
_____ X-Rayed	_____ Support (belt/brace)
_____ Rx	_____ Traction
_____ Manipulation(plus PT)	_____ Manipulation (only)
_____ Other: _____	

Did the doctor refer you to, or have you been to any other physicians? ( ) No ( ) Yes

Explain: _____

How long were you under the care of this physician? _____

Are you still under his/her care? ( ) Yes ( ) No

Indicate the frequency of your visits to the doctor: _____

Since the injury occurred, are your symptoms:

( ) Improving ( ) Getting worse ( ) Same

Past History

Have you been involved in any previous accidents of any kind? ( ) Yes ( ) No

If yes, give dates and details (use back of page if needed): _____

_____

_____

If you have been treated by any other physicians for neck or back problems, please explain: _____

_____

_____

Have you undergone any surgery? _____

_____

_____

Did you have any symptoms prior to this accident? ( ) Yes ( ) No

If yes, explain: _____

PRESENT COMPLAINTS

CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

_____ Headache	_____ Irritability	_____ Numbness in toes
_____ Face flushed	_____ Feet cold	_____ Neck pain
_____ Chest pain	_____ Shortness of breath	_____ Buzzing in ears
_____ Hands cold	_____ Neck stiffness	_____ Dizziness
_____ Fatigue	_____ Loss of Balance	_____ Stomach upset
_____ Depression	_____ Fainting	_____ Sleeping problems
_____ Constipation	_____ Loss of smell	_____ Head seems heavy
_____ Back pain	_____ Cold sweats	_____ Pins&needles in arms
_____ Nervousness	_____ Loss of memory	_____ Lights bother eyes
_____ Tension	_____ Loss of taste	_____ Pins&needles in legs
_____ Ears ring	_____ Diarrhea	_____ Numbness in fingers
_____ Fever	_____Other _____	

Symptoms other than above: _____

DISABILITY

Have you lost time from work since the accident?

( ) No ( ) Yes – number of days lost: _____

Are you still off from work? ( ) Yes ( ) No – indicate date that you returned to work: _____

What is your job description? _____

Additional comments: _____

_____

_____

_____

Physician's comments: _____

_____

_____

_____

_____

Patient's Signature: _____ Date:_____

Authorization to release records: _____ (signature)