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VEHICLE ACCIDENT INFORMATION

Patient Information

Patient Name: _____ Date: _____ SSN: _____ DOB _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Business Phone: _____
Date of accident: _____ Time of accident: _____ a.m. _____ p.m.
Please describe the accident in your own words: _____

Were you the _____ driver _____ front passenger _____ rear passenger _____ pedestrian?
How many people were in the accident? _____

ACCIDENT SITE:

Road / Street name: _____
City / State: _____ Nearest intersection with road / street: _____
Driving conditions: _____ dry _____ wet _____ icy _____ other _____
Which direction were you headed? _____ Speed you were traveling: _____

VEHICLE:

Make and model of vehicle you were in: _____
Were you wearing a seatbelt? _____ yes _____ no
If yes, what type? _____ lap _____ shoulder
Was the vehicle equipped with airbags? _____ yes _____ no
If yes, did it/they inflate properly? _____ yes _____ no
Did your seat have a headrest? _____ yes _____ no
If yes, what was the position of the headrest? _____ low _____ midposition _____ high

OTHER VEHICLE:

Make and model of other vehicle: _____
Which direction was the other vehicle headed? _____ Speed it was traveling: _____

POLICE:

Were the police at the accident site: _____ yes _____ no
Were there any witnesses? _____ yes _____ no
Was a police report filed? _____ yes _____ no
Was a traffic violation issued? _____ yes _____ no
If yes, to whom? _____

SYMPTOM/INJURIES:

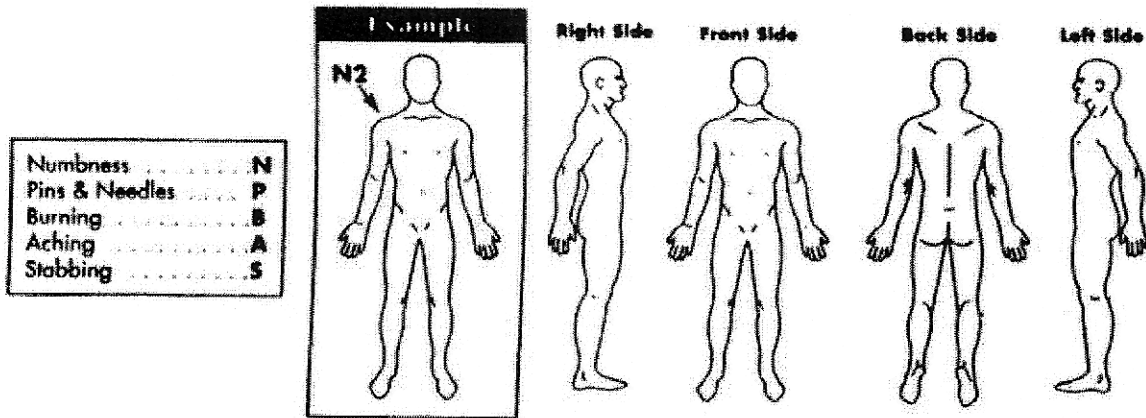
Have you been able to work since this injury? _____ yes _____ no
How many days have you missed? _____
Prior to the injury, were you able to work on an equal basis with others your age? _____ yes _____ no

If you have had any of the following symptoms since your injury please check all that apply:

<input type="checkbox"/> arm/shoulder pain	<input type="checkbox"/> back stiffness	<input type="checkbox"/> tension	<input type="checkbox"/> neck pain
<input type="checkbox"/> feet/toe numbness	<input type="checkbox"/> ear buzzing	<input type="checkbox"/> irritability	<input type="checkbox"/> stiff neck
<input type="checkbox"/> hand/finger numbness	<input type="checkbox"/> ear ringing	<input type="checkbox"/> dizziness	<input type="checkbox"/> back pain
<input type="checkbox"/> shortness of breath	<input type="checkbox"/> jaw problems	<input type="checkbox"/> fatigue	<input type="checkbox"/> leg pain
<input type="checkbox"/> sleep difficulty	<input type="checkbox"/> memory loss	<input type="checkbox"/> nausea	<input type="checkbox"/> chest pain
<input type="checkbox"/> stomach upset	<input type="checkbox"/> blurred vision	<input type="checkbox"/> headaches	

Is this condition getting progressively worse? yes no unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling. Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain).



Type of pain: sharp dull throbbing numbness aching shooting
 burning tingling cramps stiffness swelling
 other _____

How often do you have this pain? _____ Does it come and go? yes no

Is it constant or does it come and go? _____

Does it interfere with your work sleep daily routine recreation?

Activities or movements that are painful to perform: sitting standing
 walking bending lying down

I certify that the above information is correct to the best of my knowledge.

Patient signature: _____ Date: _____

Insurance Information

Major Medical Insurance (Many times your major medical insurance will pay your bill in addition to your personal injury coverage.)

Major medical insurance company: _____
Address: _____
Telephone number: _____ Identification number: _____
Policy number: _____ Coverage: _____

Auto Insurance (If you have Medical Pay Insurance or Uninsured Motorist Insurance, your company may pay your bill in addition to any other Personal Injury coverage.)

Your auto insurance company: _____
Address: _____
Telephone number: _____ Identification number: _____
Policy number: _____ Coverage: _____

Liability Coverage Insurance of Other Vehicle (If another person is at fault, their insurance may cover your needed expenses.)

Liability insurance company: _____
Address: _____
Telephone number: _____ Identification number: _____
Policy number: _____ Coverage: _____

I understand and agree that, (regardless of my insurance status); I am ultimately responsible for the balance on my account for any professional services, nutritional supplements, or orthopedic supplies. I certify this information is true and correct to the best of my knowledge.

Signature Date

Parent (if minor) Date