

Auto Accident

Patient Name: _____

Date of Birth: _____

Date of Accident: _____

Time: _____

Type of vehicle you were in: _____

Type of additional vehicle involved: _____

Location in vehicle:

Driver Front Seat Passenger Left Back Seat Passenger Right Back Seat Passenger

Number of People in the car: _____

Location of the Accident: _____

City: _____

State: _____

Which direction were you headed: North South East West

Which direction was the other car headed: North South East West

Where was your vehicle struck: Behind Front Left Side Right Side

Did you lose conscious: Yes No Did you hit your head: Yes No

Were the policy notified: Yes No Was a report filed: Yes No

Do you have a copy: Yes No Can you get a copy: Yes No

Where did you go after the accident: _____

Did you go by ambulance: Yes No What hospital: _____

What treatment did you receive: _____

Have you been seen by any other doctors for this injury or accident: Yes No

If Yes: Doctor Name: _____ Ph. # _____

Treatment: _____

Results: _____

Since the accident are your symptoms: Improving Getting Worse Getting Better No Change

Have you lost time from work: Yes No Date last worked: _____

Have you returned to work: Yes No Return Date: _____

Have you been involved in an accident in the past: Yes No

If yes, describe: _____

Do you have any previous illnesses which relate to this case: Yes No

If yes, describe _____

Do you notice any activity restrictions as a result of this injury: Yes No

If yes, describe: _____

What makes the condition feel better: _____

What makes the condition feel worse: _____

Please mark any symptoms noted after the accident:

- | | | |
|--|---|---|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Sensitivity to Light |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Head feels heavy | <input type="checkbox"/> Loss of memory |
| <input type="checkbox"/> Neck Stiffness | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Ringing in Ears |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Face Flushed |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Buzzing in Ears |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Smell |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Depression | <input type="checkbox"/> Loss of Taste |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Feet Cold | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Upset Stomach | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Fever | <input type="checkbox"/> Other _____ |

Your insurance company: _____

Adjustor(s) Name: _____ Ph: _____

Policy # _____ Claim _____

Signature: _____ Date _____