Auto Related Accident

About You

Today's Date:_____/_____/_____
Name_____
Address_____
_____
Home Telephone _____
Cell Number _____
Work Number_____
Occupation_____
Birthdate_____
Social Security #_____
Spouse's Name_____
If a minor, please give the parent's name, address and phone number
_____
_____
_____
_____

What Happened

Date of Accident_____
Time of Accident_____
Were you the: 1- Driver 2-Front Passenger
3-Rear Passenger 4-Pedestrian
How many people were in your car? _____
Was a police report filed? _____
Were you wearing a seat belt? _____
Did your car strike the other car? Y N
Did the other car strike your car? Y N
If Yes, from which side were you struck from? (circle one)
Rear Front Rt. Side Lt. side
Who received a traffic violation?
_____
Make & Model of the car you were occupying?_____
_____
Make & Model of the other person's car:
_____
_____
During impact, were you facing: (circle one)
Right, Left, Forward, I don't remember
Were you aware or surprised by the impact?
_____
Did the accident render you unconscious?
Yes No

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Please describe how you felt immediately after the accident?
_____
_____
_____
_____
Have you gone to a hospital? Y N
How did you get there?
Ambulance or private transportation
Describe any treatment you received:
_____
_____
_____
_____
_____
_____
If you saw your personal medical doctor since the accident, please write their name here.
_____
Was medication prescribed? Y N
Have you missed any days work? If yes, list the dates.
_____
_____
Did any part of your body collide with any part of the inside of the car? Please describe.
_____
_____
_____
In your words, please describe the accident
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After the Injury

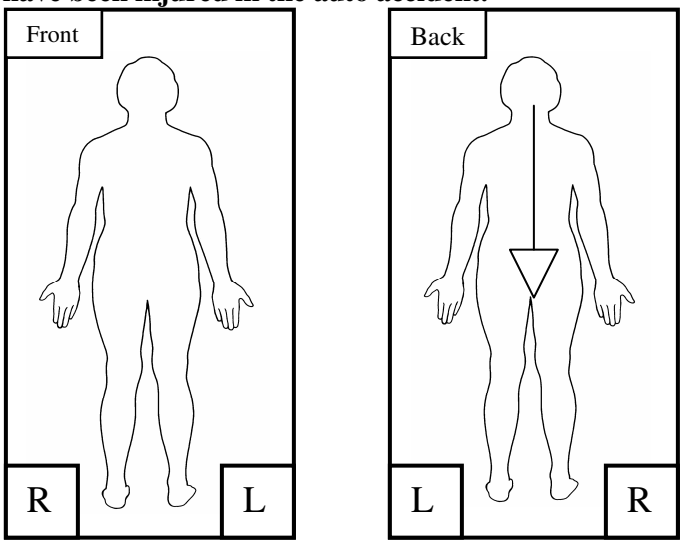
Place an X next to the symptoms that are a result of this accident:

	Neck Pain		**Numbness in legs**
	Mid-back Pain		**Numbness in Arms**
	Low-back Pain		**Numbness in Hands**
	Headaches		**Difficulty Sleeping**
	Shoulder Pain		**Pins & Needles in Arms**
	Leg Pain		**Pins & Needles in Legs**
	Foot/Ankle Pain		**Chest Pain**
	Nervousness		**Dizziness**
	Fatigue		**Nausea**
	Loss of Balance		**General Tension**
	Jaw Pain		**Depression**
	Buzzing in Ears		**Stomach Upset**
	Loss of Memory		**Shortness of Breath**

Indicate your degree of comfort while performing the following activities by placing an X in the box:

	No Pain	**Uncomfortable**	**Painful**
Lying on back			
Lying on side			
Lying on stomach			
Sitting			
Standing			
Stretching			
Walking			
Running			
Bending			
Kneeling			
Pulling			
Pushing			
Reaching			

Shade or Mark with your pen the areas that hurt or have been injured in the auto accident.



Recovery

In case we need to give any job restrictions, please fill in the following chart.

Place an X in the box next to your daily job duties and any activities that you are occasionally asked to perform:

Hours per day	**1-4**	**4-6**	**6-8**
Standing			
Sitting			
Kneeling/Squatting			
Twisting			
Bending/Stooping			
Pushing/Pulling			
Overhead reaching			
Other reaching			
Grasping/Squeezing			
Typing			
Climbing stairs/ladders			
Walking			
Running			
Operating equipment			
Crawling			
Lifting			
Answering the telephone			

I hereby swear that all the information given is factual.

Print Patient or Guardian Name

Signature of Patient or Guardian **Date**