

**AUTO ACCIDENT INFORMATION**

Date and time of accident: \_\_\_\_\_  a.m.  p.m.

Were you the:  Driver  Front Passenger  Rear passenger

Make and model of the vehicle you were occupying? \_\_\_\_\_

If a traffic violation was issued, to whom was it issued? \_\_\_\_\_

Number of people in accident vehicle? \_\_\_\_\_

Did the police come to the accident site?  Yes  No

Was a police report filed?  Yes  No

Were there any witnesses?  Yes  No

Were you wearing a seat belt?  Yes  No

Was this vehicle equipped with airbags?  Yes  No

If yes, did it/ they inflate?  Yes  No

In relation to the base of your skull, where was the headrest?  Above  Below  At base of skull

What did your vehicle impact?  Another vehicle  Other

If other, explain: \_\_\_\_\_

Did any part of your body strike anything in the vehicle?  Yes  No

If yes, please describe: \_\_\_\_\_

Make and model of the other vehicle(s) involved? \_\_\_\_\_

Name of the location/ street on which you were traveling? \_\_\_\_\_

In which direction were you headed?  N  S  E  W

What was the approx. speed of your vehicle? \_\_\_\_\_

Did the impact to your vehicle come from the :  Front  Rear  Right Side  Left Side  Other

During impact, were you facing:  Right  Left  Forward

Were you  aware or  surprised by the impact?

If accident vehicle made impact with another vehicle...

Direction other vehicle was headed?  N  S  E  W

Approximate Speed of the other vehicle? \_\_\_\_\_

In your words, please describe the accident:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**After Injury**

Did accident render you unconscious?  Yes  No

If yes, for how long? \_\_\_\_\_

Please describe how you felt immediately after the accident: \_\_\_\_\_

Have you gone to a hospital or seen any other Doctor?  Yes  No

When did you go?  Just after accident  The next day  2 days plus

How did you get there?  Ambulance  Private transportation

Name of hospital and/ or attending doctor: \_\_\_\_\_

Was he/she a:  D.C.  M.D.  D.O.  D.D.S

Describe any treatment you received: \_\_\_\_\_

Were X-Rays taken?  Yes  No

Was medication prescribed?  Yes  No

Have you been able to work since this injury?  Yes  No

Are your work activities restricted as a result of this injury?  Yes  No

Indicate the symptoms that are a result of this accident:

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Dizziness      | <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Jaw problems        | <input type="checkbox"/> Nausea          |
| <input type="checkbox"/> Memory loss    | <input type="checkbox"/> Irritability        | <input type="checkbox"/> Arms/ shoulder pain | <input type="checkbox"/> Back pain       |
| <input type="checkbox"/> Headache(s)    | <input type="checkbox"/> Fatigue             | <input type="checkbox"/> Numb hands/ fingers | <input type="checkbox"/> Lower back pain |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Tension             | <input type="checkbox"/> Chest pain          | <input type="checkbox"/> Back stiffness  |
| <input type="checkbox"/> Buzzing in ear | <input type="checkbox"/> Neck pain           | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Leg pain        |
| <input type="checkbox"/> Ears ringing   | <input type="checkbox"/> Neck stiff          | <input type="checkbox"/> Stomach upset       |  |

Other \_\_\_\_\_

Is your condition getting worse?  Yes  No  Constant  Comes and goes

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable	Painful
Lying on back.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on side.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on stomach.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stretching.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Running.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sports.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Working.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulling.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you retained an attorney:  Yes  No

If yes, whom? \_\_\_\_\_

His/ Her phone #: \_\_\_\_\_

**Recovery**

How many hours are in your normal workday? \_\_\_\_\_

Please indicate on your daily job duties and any activities, which you are occasionally asked to perform.

<input type="checkbox"/> Standing	<input type="checkbox"/> Driving	<input type="checkbox"/> Operating equipment
<input type="checkbox"/> Sitting	<input type="checkbox"/> Twisting	<input type="checkbox"/> Work with arms above
<input type="checkbox"/> Walking	<input type="checkbox"/> Crawling	head
<input type="checkbox"/> Lifting	<input type="checkbox"/> Bending	<input type="checkbox"/> Typing
		<input type="checkbox"/> Stooping

Other \_\_\_\_\_

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

What positions can you work in with minimum physical effort and for how long?

\_\_\_\_\_  N/A

Prior to the injury were you capable of working on an equal basis with others your age?  Yes  No  N/A

Do you work with others who can help you with any heavy lifting?  Yes  No  N/A

While in recovery, is there any light duty work you could request?  Yes  No  N/A

- We invite you to discuss with us any questions regarding our services. The best services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Adult patient  Parent or Guardian  Spouse