PERSONAL INJURY ACCIDENT REPORT

TODAY'S DATE: _____

Name**:** _____ Date of Birth:_____ Male/Female:____

Social Security #:_____ Marital Status:_____

Address: (complete mailing address) _____

Cell Phone No:(____)_____Cell Carrier:(ex: AT&T, Verizon, Etc.):_____

Email:_____

Right Handed: ____ Left Handed: ____ Both:____ Height: _____Weight: _____

Language Preference: _____ Interpreter Needed: Y or N If yes, please specify:_____

Emergency Contact Name:_____Phone #:_____

Doctor's Info: Name:_____Phone No:_____

Insurance Information:_____

Policy Holder (if different than patient): _____

Policy No.:_____ Claim No.: _____

Attorney Name:_____Phone No:_____

Address:_____

CHECK HERE ( ) IF YOU DO NOT HAVE AN ATTORNEY

Date/Time of Injury_____

Description of Accident/Injury/Onset -
Enter a full description of the accident, injury or onset in the space below.
For auto accidents include direction traveling: north, south, east, west, and street or highway name.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Automobile Accident Description

Please answer the questions below. If you do not know the answer to any of the questions, do not answer that question.

1. Your vehicle type
❑Car ❑Station Wagon
❑Van❑Pickup Truck
❑Large Truck ❑Bus
Other_____

2. Your position in vehicle
❑Driver ❑Front Passenger
❑Left Rear Passenger
❑Right Rear Passenger
Other_____

3. What was your vehicle doing at the time of the accident?
❑Stopped at intersection ❑Stopped in traffic ❑Stopped at light
❑Making a right turn ❑Making a left turn ❑Parking
❑Proceeding along ❑Slowing down ❑Accelerating
Other_____

4. Time/Speed/Damage
Time of accident_____
Your vehicle's speed: _____mph
Their vehicle's speed: _____mph
Damage to your vehicle
❑Mild ❑Moderate
❑Totaled

5. Details of Accident
Visibility at time of accident
❑Poor ❑Fair ❑Good

Who hit who/what?
❑You hit other vehicle
❑Other vehicle hit you
You hit...(object)
_____

6. Road conditions
Road conditions at time of accident
❑Icy ❑Wet ❑Sandy ❑Dark ❑Clean and dry

Point of impact
❑Head-On ❑Left Front ❑Right Front
❑Read-End ❑Left Rear ❑Right Rear

7. Body Position, etc.

Did you see the accident coming: **Yes❑ ❑No**
Were you braced for the impact? **Yes❑ ❑No**
Did you have a seat belt on? **Yes❑ ❑No**
Was your shoulder harness on? **Yes❑ ❑No**
Did driver side airbag deploy? **Yes❑ ❑No**

Does your vehicle have headrests? Yes❑❑No
What was the position of your headrest at the time of the impact?
❑Even with top of head ❑Even with bottom of head ❑Middle of neck
What was the direction of your head at the time of the impact?
❑Facing straight forward ❑Turned to the right ❑Turned to the left
Did passenger side airbag deploy? **Yes❑ ❑No** Side airbags? **Yes❑ ❑No**

8. Additional accident information
You were heading north east south west on _____(street or highway)
Other vehicle was headed north east south west on _____(street or highway)
Enter any additional information here that is not covered by the above check offs.

9. During the accident:
Did your body strike inside of your vehicle? **Yes❑❑No**
If yes, describe:_____
Did you lose consciousness during the injury? **Yes❑❑No**
If yes, for how long? _____
Your vehicle's estimated damage? _____
Damage to their vehicle: ❑Mild ❑Moderate ❑Totaled
Did police show up at the scene? **Yes❑ ❑No**
Was an accident report filled out? **Yes❑ ❑No**

10. After the accident:
Check off your symptoms following the accident:

❑Headache	❑Dizziness	❑Mid back pain	❑Cold hands
❑Neck pain	❑Nausea	❑Low back pain	❑Cold feet
❑Neck stiffness	❑Confusion	❑Nervousness	❑Diarrhea
❑Fainting	❑Fatigue	❑Loss of taste	❑Depression
❑Ringing in ears	❑Tension	❑Toe numbness	❑Anxious
❑Loss of smell	❑Irritability	❑Constipation	❑Chest Pain
❑Pain behind eyes	❑Shortness of breath	❑Sleeping problems	

Others:_____

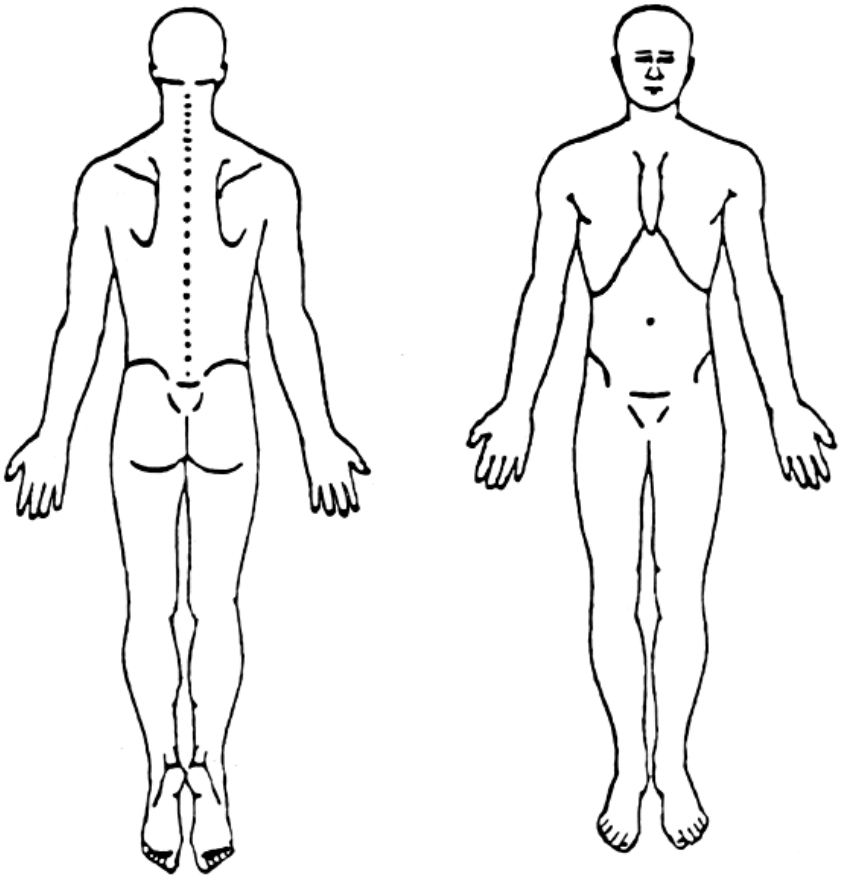
11. Emergency Room?
Where did you go after the accident?
❑Home❑Work ❑Hospital ER❑Private Doctor
How did you get there?
❑Self ❑Somebody else ❑Ambulance. ❑Police
X-rays done? Yes❑❑No Lab work? Yes❑❑No
Body parts X-rayed?_____
What lab work?_____
The X-rays revealed: _____
Treatments: ❑Cervical Collar❑Ice **Other:**____
Medications:_____
Follow-up instructions: _____
_____

12. Treatment History:
Fill in other doctor(s) seen prior to your first visit to this office.
1. Dr. _____ First visit date: ____/____/____
Specialty:_____ X-rays done? **Yes❑❑No**
Types of treatments received:_____
How many treatments received? ____ Currently treating? **Yes❑❑No**
Did treatments benefit you? **Yes❑❑No**
Last visit date: ____/____/____
2. Dr. _____ First visit date: ____/____/____
Types of treatments received:_____
How many treatments received? ____ Currently treating: **Yes❑❑No**
Did treatments benefit you? **Yes❑❑No**
Last visit date: ____/____/____

CURRENT SYMPTOMS:

Mark the areas on your body where you are having **symptoms from your injury/injuries**, Use the letter guide under this paragraph to indicate the type of symptoms in each area. Also, review the PAIN SCALE on the bottom of this page so that you are prepared to answer the doctor's questions.

P = Pain **N** = Numbness/Tingling **T** = Tenderness **B** = Burning **R** = Radiating



PAIN SCALE:

0-1	=	**Minimal**	=	The pain is an annoyance but does not stop me from working.
2-3	=	**Slight**	=	I can tolerate the pain but it causes some difficulty in doing my work. However, it does not stop me from working.
5	=	**Moderate**	=	The pain causes a marked handicap in my ability to work, but I can continue.
7-8	=	**Moderate To Severe**	=	The pain is approaching the worst I have ever experienced or could imagine. It causes a significant problem with working and most of the time I can't.
10	=	**Severe**	=	The pain is the worst I have ever experienced or could imagine and causes me to stop all work and activity.

Please LIST YOUR CURRENT SYMPTOMS/COMPLAINTS resulting from your injury:

Complaint #1: _____

What percentage of the time do you experience/feel this symptom? _____%

What activities make this symptom worse? _____

_____

What makes this symptom better? _____

_____

Can/Do you have this symptom without activity? _____

PAIN SCALE _____ *0 - 10. The doctor will discuss this with you.*

Complaint #2: _____

What percentage of the time do you experience/feel this symptom? _____%

What activities make this symptom worse? _____

_____

What makes this symptom better? _____

_____

Can/Do you have this symptom without activity? _____

PAIN SCALE _____ *0 - 10. The doctor will discuss this with you.*

Complaint #3: _____

What percentage of the time do you experience/feel this symptom? _____%

What activities make this symptom worse? _____

_____

What makes this symptom better? _____

_____

Can/Do you have this symptom without activity? _____

PAIN SCALE _____ *0 - 10. The doctor will discuss this with you.*

Complaint #4: _____

What percentage of the time do you experience/feel this symptom? _____%

What activities make this symptom worse? _____

_____

What makes this symptom better? _____

_____

Can/Do you have this symptom without activity? _____

PAIN SCALE _____ *0 - 10. The doctor will discuss this with you.*

If needed, list additional symptoms or complaints on the back of this page

PAST MEDICAL HISTORY:

Please list **Information About Your Medical History** in the sections below, with **approximate dates**.
If a section does not apply to you, mark an **(X)** in the parentheses, DO NO LEAVE ANY BLANK:

Childhood Illnesses: ( )_____
_____
_____

Childhood Injuries: ( ) _____
_____
_____

Allergies: ( ) _____
_____
_____

Present Medications Taken (Prescription & Over-The-Counter): ( )_____
_____
_____

Surgeries: ( ) _____
_____
_____

Hospitalizations: ( ) _____
_____
_____

Adult Illnesses: ( ) _____
_____
_____

REVIEW OF SYSTEMS:

Please list any **current problems** that you have with the body systems listed below.
If a section does not apply to you, mark an **(X)** in the parentheses, DO NO LEAVE ANY BLANK:

Ears/Nose/Throat: ( ) _____
Eyes: ( ) _____
Lungs: ( ) _____
Liver: ( )_____
G-I Tract (Stomach, Intestines, Bowels, Etc.): ( ) _____
Kidney/Bladder: ( ) _____
[Women] Reproductive System: ( )_____
Skin: ( ) _____
Neurological: ( )_____
Heart/Circulation: ( ) _____
Psychological: ( ) _____