

# AUTO INJURY

## PERSONAL INFORMATION

Today's Date \_\_\_\_\_ Date of Accident \_\_\_\_\_  
Name \_\_\_\_\_ Date of birth \_\_\_\_\_ S.S. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ Cell phone \_\_\_\_\_  
Email \_\_\_\_\_ Ok to send you our monthly e-newsletter? Yes No  
Spouse's name (if married) \_\_\_\_\_ Children?(names/ages) \_\_\_\_\_  
\_\_\_\_\_  
Emergency contact \_\_\_\_\_ Phone \_\_\_\_\_

## EMPLOYMENT INFORMATION

Employer \_\_\_\_\_ Address \_\_\_\_\_  
Job title \_\_\_\_\_ How many hours per week do you normally work? \_\_\_\_\_  
What are the physical requirements of your job? \_\_\_\_\_  
\_\_\_\_\_  
How have your injuries affected your ability to work? \_\_\_\_\_  
\_\_\_\_\_  
Please list any days of work missed as a result of this accident \_\_\_\_\_  
Is light-duty work available, if needed? Yes No

## MEDICAL HISTORY

Have you ever been injured in a previous auto accident (sore afterwards)? Yes No  
If yes, approximate dates, and describe your injuries \_\_\_\_\_  
\_\_\_\_\_  
Please list any significant injuries or physical traumas you have had during your life \_\_\_\_\_  
\_\_\_\_\_  
Have you had ongoing problems as a result of any of these injuries? Yes No  
If yes, please describe \_\_\_\_\_  
\_\_\_\_\_  
Please list any current health problems \_\_\_\_\_  
\_\_\_\_\_  
Please list all medications you currently take \_\_\_\_\_  
\_\_\_\_\_  
Please list vitamins/supplements you take \_\_\_\_\_  
\_\_\_\_\_

**ABOUT THE ACCIDENT**

Date of accident \_\_\_\_\_ Time of day \_\_\_\_AM/PM

Please describe the accident in your own words:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please illustrate what happened in your accident:

Police on the scene? Y N / Report filed? Y N

You were the:(check one)

Driver  Front seat Passenger

Backseat Passenger (circle one) Left Right

Were you wearing your seatbelt? Y N

Did the airbags deploy? Y N

Were you aware of the impending crash? Y N

Did your head or body strike any parts of the vehicle? Please describe: \_\_\_\_\_

Was the seat back or head restraint position altered by the accident? Y N

Did you lose consciousness at any point? Y N If so, for how long? \_\_\_\_\_

Did you go to the hospital following the accident? Y N / Which one? \_\_\_\_\_

If yes: How did you get there? \_\_\_\_\_

What tests were taken and what were the findings? \_\_\_\_\_

What medications were prescribed? \_\_\_\_\_

What medical attention have you received so far? \_\_\_\_\_

Please list any other passengers with you: \_\_\_\_\_

Year, make, model of your vehicle: \_\_\_\_\_

Describe other vehicle: \_\_\_\_\_

Type of damage: \_\_\_\_\_

Amount of damage to auto: \$ \_\_\_\_\_

Road conditions: \_\_\_\_\_

**VI. SYMPTOMS**

Check symptoms you have noticed since the accident:

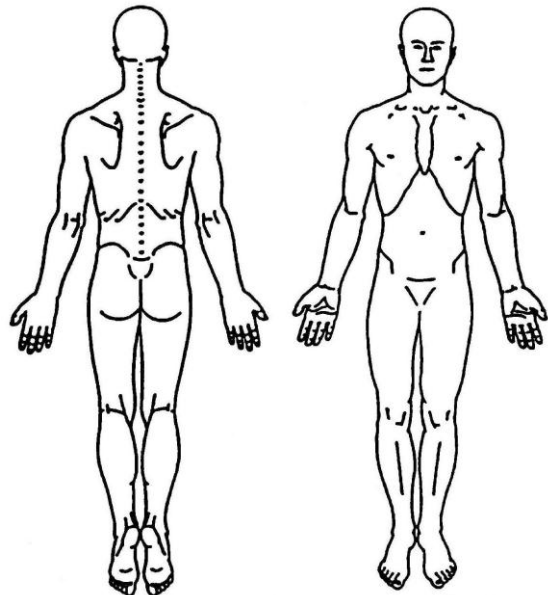
<input type="checkbox"/> Neck pain or stiffness	<input type="checkbox"/> Loss of Memory
<input type="checkbox"/> Upper back pain	<input type="checkbox"/> Loss of Smell or Taste
<input type="checkbox"/> Mid back pain	<input type="checkbox"/> Light bothers Eyes
<input type="checkbox"/> Lower back pain	<input type="checkbox"/> Trouble focusing (vision)
<input type="checkbox"/> Jaw Problems	<input type="checkbox"/> Ringing/Buzzing in Ears
<input type="checkbox"/> Shoulder pain	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Nausea
<input type="checkbox"/> Pain/Numbness in arms/hands	<input type="checkbox"/> Poor appetite
<input type="checkbox"/> Pain/Numbness in legs/feet	<input type="checkbox"/> Trouble falling asleep
<input type="checkbox"/> Headaches	<input type="checkbox"/> Wake up during the night

Other symptoms: \_\_\_\_\_

Where are you hurting the worst? \_\_\_\_\_

Is your condition getting worse, better, or staying the same? \_\_\_\_\_

Please mark the location(s) of your pain or numbness, and number from most bothersome to least:



Bruising? Where? \_\_\_\_\_