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

Year, make, model of your vehicle:________________

Describe other vehicle:__________________________

Type of damage:________________________________

Amount of damage to auto: $____________________

Road conditions:________________________________

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:____ _____

VI. SYMPTOMS

Check symptoms you have noticed since the accident:

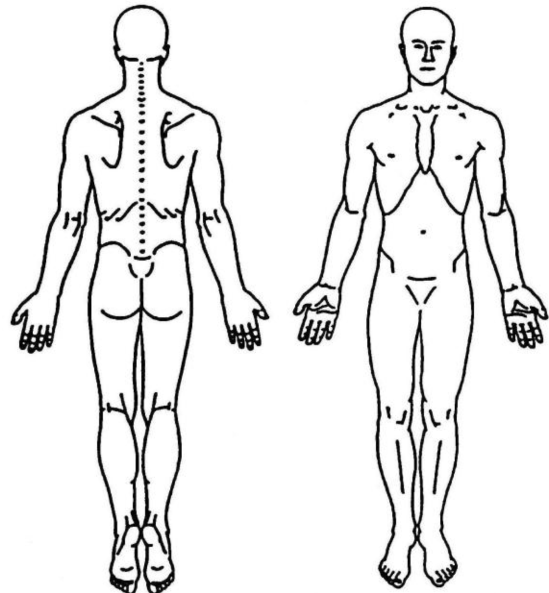
❑ Neck pain or stiffness	❑ Loss of Memory
❑ Upper back pain	❑ Loss of Smell or Taste
❑ Mid back pain	❑ Light bothers Eyes
❑ Lower back pain	❑ Trouble focusing (vision)
❑ Jaw Problems	❑ Dizziness
❑ Shoulder pain	❑ Fatigue
❑ Chest Pain	❑ Nausea
❑ Pain/Numbness in arms/hands	❑ Trouble with balance
❑ Pain/Numbness in legs/feet	❑ Trouble falling asleep
❑ Headaches	❑ 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?________________________