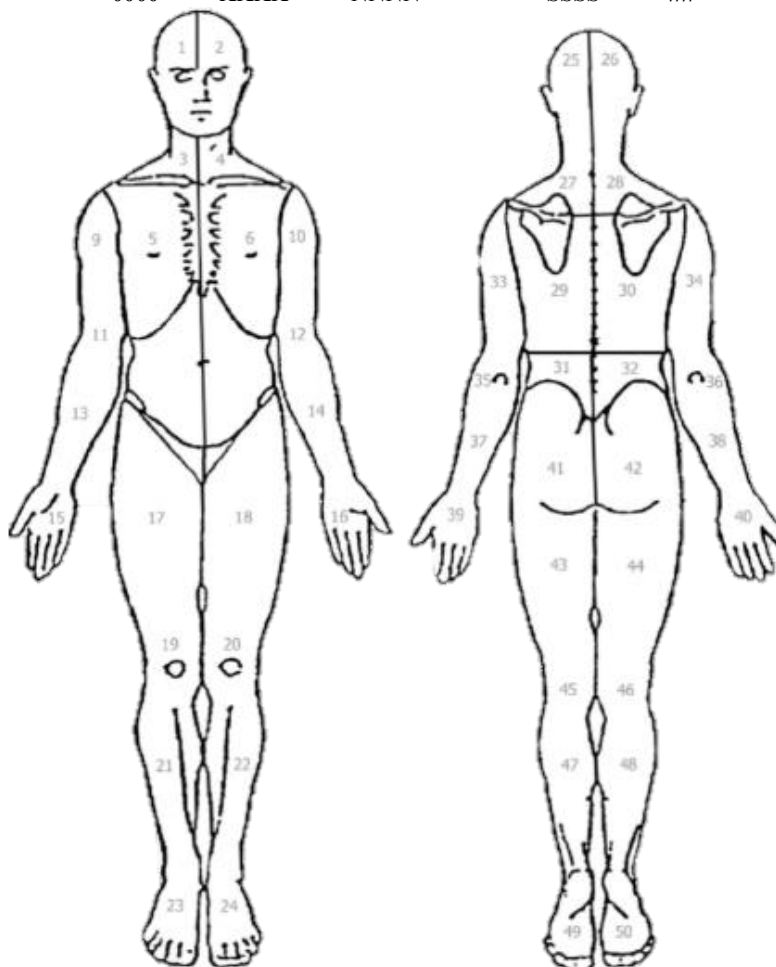


Name: _____ Date: _____

Date of Birth: _____ Date of Injury: _____ Gender: ☐ Male ☐ Female

Please note your symptoms since the accident on the picture below using the following notations:

Abrasion	Contusion	PAIN	Numbness/Tingling	Spasms	Stabbing
====	0000	XXXX	NNNN	SSSS	////



SYMPTOMS: Please check all that you have experienced since the crash.

- | | | |
|---|--|--|
| ☐ Headaches | ☐ Visual Disturbance | ☐ Fatigue |
| ☐ Dizziness | ☐ Sensitivity to Light | ☐ Balance Problems |
| ☐ Difficulty Concentrating | ☐ Sensitivity to Sound | ☐ Stiffness |
| ☐ Stress (Anxiety/Depression) | ☐ Ringing in Ears | ☐ Muscle Spasms |
| ☐ Sleep Disturbance | ☐ Nausea | ☐ Radiating Pain |
| ☐ Behavioral Changes | ☐ Vomiting | ☐ Numbness/Tingling |
| ☐ Difficulty Remembering | ☐ Grinding/Clenching of Teeth/TMJ | ☐ Range of Motion Limitations |
| ☐ Loss of Consciousness: Duration _____ | | |
| ☐ Superficial Injuries (Abrasions, Contusions, Lacerations, Burns): Body Part(s) _____ | | |

☐ Hit a Body Part Inside the Vehicle: Body Part(s) & Vehicle Part(s) _____

DUTIES UNDER DURESS / LOSS OF ENJOYMENT: tasks that are **difficult** or you are **unable** to perform due to pain

- ☐ Work
- ☐ Study
- ☐ Domestic Duties (Tasks inside the home: cleaning, cooking, childcare, personal hygiene...)
- ☐ Household Duties (Tasks outside the home: driving, taking out trash, yardwork...)
- ☐ Hobbies
- ☐ Sports (Any type from recreational to professional)

PATIENT INFORMATION:

Name: _____ Marital Status: _____ Date: _____ Date of Injury: _____
Address: _____ City: _____ State: _____ ZIP: _____
E-mail: _____ SSN: _____ - _____ - _____
Date of Birth: ____/____/____ Gender: ☐ Male ☐ Female Height: _____ Weight: _____
Employer: _____ Employer Address: _____
Work Phone: _____

EMERGENCY CONTACT:

Name: _____ Phone #: _____ Relationship to Patient: _____

INSURANCE INFORMATION:

Auto Insurance Company: _____ Claim Number: _____
Insurance Company Phone: _____ Claims Adjuster: _____

Health Insurance Company: _____
Policyholder Name: _____ Date of Birth: _____ Relationship to Patient: _____
Member Number: _____ Group Number: _____

ATTORNEY INFORMATION:

Have you retained an attorney? ☐ Yes ☐ No
Law Firm Name: _____ Law Firm Phone: _____

CRASH INFORMATION:

Date: _____ Location: _____ How many vehicles were involved? _____

Your Approximate Speed: _____ Approximate Speed of the Other Vehicle(s): _____

Type of Collision: ☐ Rear-end ☐ Head on ☐ Rollover ☐ Side swipe ☐ T-bone ☐ Vehicle vs. Pedestrian/Cyclist
☐ Other: _____

Your Impact Location: ☐ Center ☐ Passenger Side ☐ Driver Side ☐ Front Door ☐ Rear Door ☐ Other: _____

Was your vehicle drivable after the collision? ☐ Yes ☐ No

Were you wearing a seatbelt? ☐ Yes ☐ No Did the airbags deploy? ☐ Yes ☐ No Did you brace for impact? ☐ Yes ☐ No

Your seated position in the vehicle: ☐ Driver ☐ Front Passenger ☐ Right Rear Passenger ☐ Left Rear Passenger

☐ Other: _____

At the time of impact were you: ☐ Facing Forward ☐ Head Turned to the Right ☐ Head Turned to the Left ☐ Torso Turned to the Right

☐ Torso Turned to the Left ☐ Other: _____

Did you strike any part of the vehicle? ☐ Yes ☐ No If so, please describe: _____

Were you on the job at the time of the collision? ☐ Yes ☐ No If so, has this been reported to your employer? ☐ Yes ☐ No

Were you treated by EMS? ☐ Yes ☐ No Did you go to a hospital or urgent care? ☐ Yes ☐ No



Were you hospitalized as a result of the crash? If so, please provide the name and location of the hospital and a brief description of the treatments you received:

Have you seen any other doctors for this crash? ☐ Yes ☐ No

Physician

Date(s) of Service

Treatment

What medications/supplements are you currently taking, if any?

Medication/Supplement Name

Dosage

Frequency

Purpose

Do you have any **prior** injuries/conditions that have been aggravated by this crash? ☐ Yes ☐ No Please describe: _____

Were you ever granted permanent disability/impairment for any **prior** injury/condition? ☐ Yes ☐ No Please describe: _____

Have you had any significant **new** injuries since this crash? ☐ Yes ☐ No Please describe: _____

Before the accident, would you say your health was: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Since the accident has your pain level: ☐ Increased ☐ Decreased ☐ Stayed the same ☐ Come and gone

PAIN SCALE:

Please rate your pain at best, at worst, and average on a scale of 1 to 10 (with 10 being the worst pain).

At best: _____

At worst: _____

Average: _____

What makes it feel better? ☐ Rest ☐ Movement ☐ Over the Counter Medications ☐ Prescriptions ☐ Nothing

What makes it feel worse? ☐ Rest ☐ Movement ☐ Over the Counter Medications ☐ Prescriptions ☐ Nothing

Is there anything else we should know? Please describe: _____

Signature: _____ Date: _____

Physician Signature: _____ Date: _____

