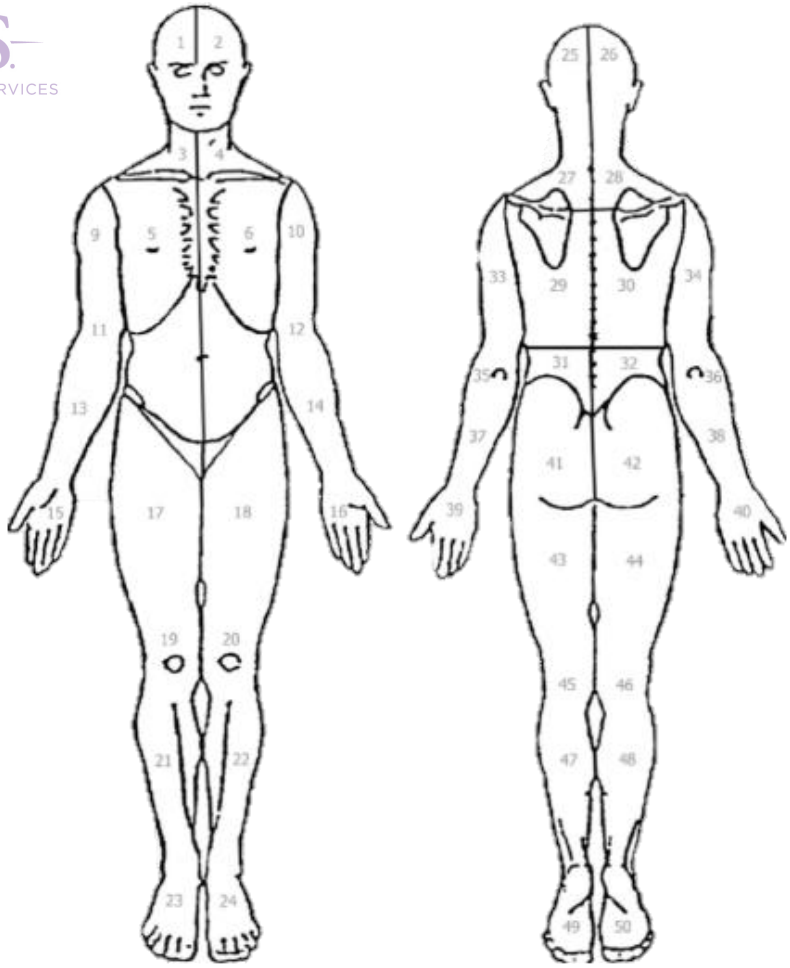
Name: _____ Date: _____

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
☐ Dizziness
☐ Difficulty Concentrating
☐ Stress (Anxiety/Depression)
☐ Sleep Disturbance
☐ Behavioral Changes
☐ Difficulty Remembering
☐ Visual Disturbance
☐ Sensitivity to Light
☐ Sensitivity to Sound
☐ Ringing in Ears
☐ Nausea
☐ Vomiting
☐ Grinding/Clenching of Teeth/TMJ
☐ Fatigue
☐ Balance Problems
☐ Stiffness
☐ Muscle Spasms
☐ Radiating Pain
☐ Numbness/Tingling
☐ 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

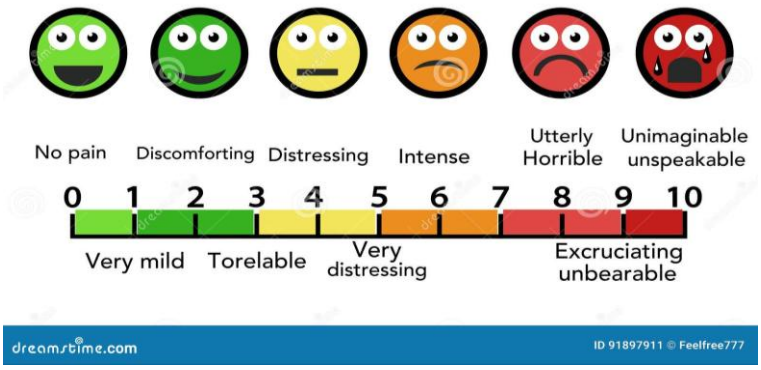
PAIN SCALE:

Please rate your pain at best, at worst, and average based on the diagram.

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: _____