CASE ANALYSIS & CLIENT INFORMATION

FULL name _____ Date _____

Please list any other names (e.g. maiden name) you have *ever* used:

Name	Dates Used
_____	_____
_____	_____

Address: _____City_____ Zip _____

Phone (cell)_____(home)_____(work)_____(fax)_____

e-mail_____Spouse_____

Date of Birth:_____SSN:_____Driver's License #:_____

Emergency Contact #1: _____ Phone # _____

Emergency Contact #2: _____ Phone # _____

Who Referred You To Our Office? _____

Body Shop _____ Phone _____

Repairs paid by Defendant's Ins. Client's Ins.

Cost of repairing your car: $_____ Has your car been repaired? Yes No

Insurance Information

Client's Car Insurance Company:_____ Phone # _____

Policy # _____ In Force? Yes No Claim # _____

Adjustor _____ Phone # _____ Fax # _____

UM Limits _____ MedPay Limits _____

Your Health Insurance Company _____

Health Ins. Policy # _____ Phone _____

1st OTHER DRIVER

Name _____

Address _____ City _____Zip _____

Home Phone _____ Cell _____ Work Phone _____

DL # _____ State _____ Make _____ Model _____ License _____

1st Other Driver's Car Ins. Company (on SR1) _____

Address _____ City _____ Zip _____

Claim # _____ Policy # _____

Adjustor's Name _____ Phone # _____ Fax # _____

Facts of the Collision (When no TCR, Fill out SR1 & Info Below)

Police Appear Y N TCR Y N #_____ Dept. _____

DOI: _____ Time of Crash _____

City/Location of Accident _____

Alcohol/Drugs Involved? _____

Accident Description _____

WITNESSES

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

1ST OTHER CAR OWNER

Name _____ Company _____

Address _____ City _____Zip _____

Home Phone _____ Cell _____ Work Phone _____

Is 1st Other Owner the Employer N Y

1st Registered Owner's Car Ins. Company (on SR1) _____

Address _____ City _____ Zip _____

Claim # _____ Policy # _____

Adjustor's Name _____ Phone # _____ Fax # _____

2nd OTHER DRIVER (2nd DEFENDANT IN ACCIDENT)

Name _____

Address _____ City _____Zip _____

Home Phone _____ Cell _____ Work Phone _____

DL # _____ State _____ Make _____ Model _____ License _____

2nd Driver's Car Ins. Company _____

Address _____ City _____ Zip _____

Claim # _____ Policy # _____

Adjustor's Name _____ Phone # _____ Fax # _____

2nd Car Registered Owner's Car Ins. Company _____

Name of registered owner of 2nd car _____

Address _____ City _____ Zip _____

Claim # _____ Policy # _____

Adjustor's Name _____ Phone # _____ Fax # _____

Is 2nd Other Owner the Employer N Y

3rd OTHER DRIVER (3rd DEFENDANT IN ACCIDENT)

Name _____

Address _____ City _____Zip _____

Home Phone _____ Cell _____ Work Phone _____

DL # _____ State _____ Make _____ Model _____ License _____

3rd Driver's Car Ins. Company _____

Address _____ City _____ Zip _____

Claim # _____ Policy # _____

Adjustor's Name _____ Phone # _____ Fax # _____

3rd Car's Registered Owner's Car Ins. Company _____

Name of registered owner of 3rd car _____

Address _____ City _____ Zip _____

Claim # _____ Policy # _____

Adjustor's Name _____ Phone # _____ Fax # _____

Is 1st Other Owner the Employer N Y

YOUR Medical History <u>After</u> This Collision

Ambulance Company _____ Phone _____

Do you have the Ambulance Bill? Yes No Ambulance Bill $ _____ Pd by _____

Hospital #1_____ Phone # _____

Did you stay overnight? Yes No How many days were you in the hospital? _____

Hospital #2_____ Phone # _____

Did you stay overnight? Yes No How many days were you in the hospital? _____

What **<u>other</u>** doctors, dentists, PT, acupuncture, optometrist, chiropractors have you seen since accident?

#1_____ Type of medical provider? _____

Address _____ City _____ Zip _____

Phone _____ Fax _____

#2_____ Type of medical provider? _____

Address _____ City _____ Zip _____

Phone _____ Fax _____

#3_____ Type of medical provider? _____

Address _____ City _____ Zip _____

Phone _____ Fax _____

#4_____ Type of medical provider? _____

Address _____ City _____ Zip _____

Phone _____ Fax _____

#5_____ Type of medical provider? _____

Address _____ City _____ Zip _____

Phone _____ Fax _____

#6_____ Type of medical provider? _____

Address _____ City _____ Zip _____

Phone _____ Fax _____

Medical History Before This Collision

Have you EVER had any Motor Vehicle Accidents, Workers Compensation Claims, or other claims of Injury of ANY type? Yes No If yes, when? _____

_____

Who is your **regular doctor**? Name:_____ How Long? _____

Address:_____ City _____ Zip _____

Phone:_____ Fax _____

List all **serious illnesses, accidents, or time spent in hospital** during your life:

#1_____ Doctor's Name _____

Address _____ City _____ Zip _____

Phone _____ Fax _____

#2_____ Doctor's Name _____

Address _____ City _____ Zip _____

Phone _____ Fax _____

#3_____ Doctor's Name _____

Address _____ City _____ Zip _____

Phone _____ Fax _____

#4_____ Doctor's Name _____

Address _____ City _____ Zip _____

Phone _____ Fax _____

#5_____ Doctor's Name _____

Address _____ City _____ Zip _____

Phone _____ Fax _____

Employer at Time of Collision:_____

Address:_____City _____ZIP _____

Job Title:_____Job Duties:_____

Worked There Since _____ Supervisor _____

Have you missed any time from work because of this collision? Yes No When? _____

Were you on duty at work when this accident occurred? Yes No In what capacity? _____

If there were any PASSENGERS in your car, please give us this information

Passenger #1_____ Relationship to you _____

Address _____ Phone # _____

Injuries to this Passenger _____

Doctor treating him/her _____ Phone # _____

Date of Birth: _____ Social Security # _____ Driver License # _____

Passenger #2_____ Relationship to you _____

Address _____ Phone # _____

Injuries to this Passenger _____

Doctor treating him/her _____ Phone # _____

Date of Birth: _____ Social Security # _____ Driver License # _____

Passenger #3_____ Relationship to you _____

Address _____ Phone # _____

Injuries to this Passenger _____

Doctor treating him/her _____ Phone # _____

Date of Birth: _____ Social Security # _____ Driver License # _____

Passenger #4_____ Relationship to you _____

Address _____ Phone # _____

Injuries to this Passenger _____

Doctor treating him/her _____ Phone # _____

Date of Birth: _____ Social Security # _____ Driver License # _____

	Received	Will Send	Doesn't Have	Doesn't Exist
Police Report	( )	( )	( )	( )
Client's Ins. Dec. Page	( )	( )	( )	( )
Letters from Client's Ins. Co	( )	( )	( )	( )
Letters from Def's Ins. Co.	( )	( )	( )	( )
Letters from 2nd, 3rd Ins. Co.	( )	( )	( )	( )
Repair Estimate	( )	( )	( )	( )
Pictures of Client's Car Damage	( )	( )	( )	( )
Pictures of Def's Car Damage	( )	( )	( )	( )
Picture of Client's Injuries	( )	( )	( )	( )
Medical Bills	( )	( )	( )	( )
Health Insurance Card	( )	( )	( )	( )
Personal Prop. Documentation	( )	( )	( )	( )

Symptoms

Patient _____ Date _____ Date of Injury _____

Please fill in all symptoms you currently have <u>that you did not have</u> before the accident.

Orthopedic & Musculoskeletal Symptoms

- ☐ "Clunk" sound with neck movements
- ☐ Neck pain
- ☐ Upper back pain
- ☐ Low back pain
- ☐ Shoulder pain ☐ Left ☐ Right
- ☐ Upper arm pain ☐ Left ☐ Right
- ☐ Elbow pain ☐ Left ☐ Right
- ☐ Forearm pain ☐ Left ☐ Right
- ☐ Wrist pain ☐ Left ☐ Right
- ☐ Hand pain ☐ Left ☐ Right
- ☐ Hip pain ☐ Left ☐ Right
- ☐ Upper leg pain ☐ Left ☐ Right
- ☐ Knee pain ☐ Left ☐ Right
- ☐ Lower leg pain ☐ Left ☐ Right
- ☐ Ankle pain ☐ Left ☐ Right
- ☐ Foot pain ☐ Left ☐ Right
- ☐ Jaw pain
- ☐ Clicking in Jaw
- ☐ Pain when chewing
- ☐ Face pain
- ☐ Chest pain
- ☐ Stomach pain
- ☐ Bruise to _____
- ☐ Scrape/Cut to _____
- ☐ Other Symptom _____
- ☐ Other Symptom _____

Neurological Symptoms

- ☐ Numb/Tingling Arm / Hand L R
- ☐ Numb/Tingling Leg / Foot L R
- ☐ Weakness Arm / Hand L R
- ☐ Weakness Leg / Foot L R

Symptoms Associated with Injuries

- ☐ Stiffness or limited movement in joint(s)
- ☐ Headaches
- ☐ Muscle spasms/sore muscles
- ☐ Dizziness, lightheaded, woozy feeling
- ☐ Visual disturbances or vision change
- ☐ Sleep changes/disruption of patterns
- ☐ Pain radiates from one place to another
- ☐ Anxiety or nervous when driving
- ☐ Irregular Heartbeat or uneven pulse
- ☐ Feeling depressed about things
- ☐ I am taking medications _____

Brain/Neuropsych/MTBI/PTSD Symptoms

- ☐ I prefer being alone now (not socializing)
- ☐ I am sleepy, tired during day or doze off easily
- ☐ Upset stomach, nausea, heartburn or vomiting
- ☐ Difficulty concentrating, mind wanders easily
- ☐ I get overwhelmed easily
- ☐ Mood swings, happy one moment then sad
- ☐ Agitation (can't sit still, need to move around)
- ☐ Sadness, tearful episodes, crying easily
- ☐ Blurry vision, had to get or change glasses
- ☐ Asking people to repeat things or hearing problem
- ☐ I make wrong turns driving or can't remember time
- ☐ I get confused easily or cannot multi-task anymore
- ☐ I have difficulty finding some words when talking
- ☐ Bright lights bother me
- ☐ I cannot pay attention as long as before
- ☐ I am eating more or less than normal
- ☐ Room spins, lightheaded or woozy feeling
- ☐ Balance problems
- ☐ I feel like my head is "Foggy"
- ☐ I have forgotten computer passwords or ATM PIN
- ☐ I have to re-read things to understand what I read
- ☐ My thinking is slowed down
- ☐ Difficulty with adding/subtracting numbers
- ☐ Fear I will never be the same again
- ☐ Difficulty learning new things
- ☐ Difficulty understanding what people say to me
- ☐ Difficulty remembering or memory problems
- ☐ Cannot take on any more responsibility
- ☐ I can't make decisions as quickly as before
- ☐ Loss of libido or lack of sexual desire
- ☐ I do not feel as confident of my abilities
- ☐ I get panic attacks, fast heartbeat, nervous
- ☐ I am more irritable than usual
- ☐ Some food or drink tastes "Funny" to me now
- ☐ I get frustrated very easily
- ☐ Difficulty planning my life or organizing my work
- ☐ Flashbacks or frightening thoughts about accident
- ☐ I have had bad dreams about the accident
- ☐ I avoid places & objects that remind me about it
- ☐ I feel emotionally numb-no interest in my hobbies
- ☐ I'm feeling strong guilt, worry or depression
- ☐ I am having trouble remembering the accident
- ☐ I am easily startled since the accident - "jumpy"
- ☐ I feel tense or "on edge" most of the time
- ☐ I am having difficulty sleeping
- ☐ I get angry easily or even yell at people now

Client Background

Military Service? _____

Scouts or youth programs? _____

Name of High School _____ Date of Graduation _____

High School GPA? _____ Clubs or Music Participation? _____

High School Sports Teams? _____

High School Drama Club? _____ Debate or Speaking Team? _____

College Degree(s)? _____ Name of College _____

Have you served as a mentor or participated in community groups to assist the need? _____

Describe your service: _____

Married to? _____ since _____. Children's ages _____

Grandchildren's ages _____

PTA? _____

Do you attend Church? _____ Where? _____

What hobbies can't you do because of this accident? _____

_____

What Athletics/Sports can't you do because of this accident? _____

_____

What Social Networking site are you on?

Facebook? Yes No Instagram? Yes No Twitter? Yes No

Linked In? Yes No Other? Yes No _____

I understand I am NOT to post ANYTHING about this accident on social media. _____ (Initial)

I understand I am NOT to let friends post about me or my accident for 2 years. _____ (Initial)

I understand insurance companies will look at social media to look for pictures or posts that will hurt my case _____ (Initial)

Have you ever been convicted of a felony? Yes No