## *******ACCIDENT RELATED INFORMATION*******

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|---|---|
| Was your injury a result of: | ☐ Auto Accident ☐ Slip & Fall ☐ Other: |
| Accident Date: | If Auto, amount of damage to your vehicle: $_____ |
| Please describe how this accident happened: | |
| Your Current Symptoms? | |
| Name of doctor(s) currently treating you for this injury? | |
| Have you ever been treated for any previous accidents? | ☐ Yes ☐ No When?:_____ |
| Have you had any of the following treatments for your current injury? | Physical Therapy ☐ Yes ☐ No<br>Chiropractic Treatment ☐ Yes ☐ No<br>Traction ☐ Yes ☐ No<br>E-Stim/TENS Treatment ☐ Yes ☐ No<br>Trigger Point Injections ☐ Yes ☐ No<br>Epidural Steroid Injections ☐ Yes ☐ No<br>Medications ☐ Yes ☐ No |
| Do you have an attorney? ☐ Yes ☐ No | Attorney/Firm Name: |
| Contact person at firm & phone # | |