Auto Injury Information

Name _____ Today's Date _____

Date of Accident _____ Time of Accident _____ AM PM

Location of Accident

_____

Type of Accident: [ ] Auto/Traffic [ ] Work/On Job [ ] At Home [ ] Other

_____

Describe how the accident happened in your own words:

_____

_____

_____

_____

Name of Hospital: _____ Attended by Dr. _____

Were you x-rayed at the hospital? [ ] Yes [ ] No If so, what was the diagnosis? _____

Were you admitted to the hospital? [ ] Yes [ ] No How long did you stay? _____

What treatment was rendered?

_____

What recommendations were made?

_____

List any other doctors you have seen as a result of this accident:

_____

_____

Have you lost any time from work because of this accident? [ ] Yes [ ] No If yes, give days of disability: _____

Totally disabled from _____ to _____ Partially disabled from _____ to _____

Have you returned to work since the accident? [ ] Yes [ ] No Were you wearing a seat belt? [ ] Yes [ ] No

What kind of vehicle hit yours? _____ What kind of vehicle were you in? _____

If auto accident, were you the [ ] Driver [ ] Passenger [ ] Pedestrian?

If passenger, were you sitting in the [ ] Front [ ] Right Rear [ ] Left Rear?

Did your vehicle hit other vehicle(s)? [ ] Yes [ ] No Estimated speed of your vehicle at impact? _____ MPH

Was your vehicle hit by another vehicle(s)? [ ] Yes [ ] No Estimated speed of other vehicle at impact? _____ MPH

Did your car strike the other(s) involved? [ ] Yes [ ] No or did the other car strike yours? [ ] Yes [ ] No [ ] Undetermined

VEHICLE YOU WERE IN:
Driver

Insured:

Address:

Phone:

Auto Insurance Co.:

Ins. Co. Address:

Adjuster:

Phone:

Policy #:

Claim #

OTHER VEHICLE
Driver:

Insured:

Address:

Phone:

Auto Insurance Co.:

Ins. Co. Address:

Adjuster:

Phone:

Policy #:

Claim #

Did you require post-accident hospitalization? [ ] Yes [ ] No

CHECK THE SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

[ ] Headache
[ ] Neck Pain
[ ] Neck Stiff
[ ] Sleeping Problems
[ ] Back Pain
[ ] Nervousness
[ ] Tension

[ ] Irritability
[ ] Chest Pain
[ ] Dizziness
[ ] Head seems too heavy
[ ] Pins & Needles in Arms
[ ] Pins & Needles in Legs
[ ] Numbness in Fingers

[ ] Numbness in Toes
[ ] Shortness of Breath
[ ] Fatigue
[ ] Depression
[ ] Light bothers Eyes
[ ] Loss of Memory
[ ] Ears Ring

[ ] Face Flushed
[ ] Buzzing in Ears
[ ] Loss of Balance
[ ] Fainting Spells
[ ] Loss of Smell
[ ] Loss of Taste
[ ] Diarrhea

[ ] Feet Cold
[ ] Hands Cold
[ ] Stomach Upset
[ ] Constipation
[ ] Cold Sweats
[ ] Fever
[ ] _____

Symptoms other than above:

Have you lost days of work? [ ] YES [ ] NO Dates:

Name of your Insurance Company involved:

Name of person at your Insurance Company responsible for injuries:

Have you been contacted by an Insurance Adjuster or Company Representative regarding this claim? [ ] YES [} NO

Do you have an attorney who has advised you in this case? [ ] YES [ ] NO Name: _____

Address of Attorney: _____ Phone No: _____

Patient's Signature: _____ Date: _____