

# -- Auto Accident Information --

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Please complete this packet as completely and as accurately as your current condition allows. Where response choices are required, please use a check mark “√” to indicate the most appropriate answer. If a question does not apply to you, please write “N/A” (not applicable). If you are unsure about how to accurately answer a question, write a “?” next to it. Please PRINT all responses and ask for assistance if you have any questions.

Patient's Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_ Date of Injury: \_\_\_\_\_  
Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender:  M  F Marital Status: \_\_\_\_\_ SS#: \_\_\_\_\_  
Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: (\_\_\_\_) \_\_\_\_\_ Mobile Phone: (\_\_\_\_) \_\_\_\_\_ Email Address: \_\_\_\_\_  
Emergency Contact Name: \_\_\_\_\_ Emergency Phone: (\_\_\_\_) \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

At the time of the collision, who was driving the vehicle you were in?  I was  The person indicated below was driving:  
(Do Not Complete This Section If **You** Were the Driver) Driver's Name: \_\_\_\_\_  
Driver's Address: \_\_\_\_\_ Driver's Phone: (\_\_\_\_) \_\_\_\_\_

Was the vehicle registered to you?  Yes  No If not, who was it registered to? \_\_\_\_\_

Your seating position in the vehicle:  Front Seat  Back Seat /  Left  Right  Center \_\_\_\_\_

Was anyone else in the vehicle with you at the time of the collision?  Yes  No If yes, identify all persons below:

	Name	Relationship	Age	Injured?		
1.	_____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
2.	_____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
3.	_____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
4.	_____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure

Were you on the job at the time of the collision?  Yes  No If yes, was it reported to your employer?  Yes  No

Location of the accident: \_\_\_\_\_

What were the road and weather conditions like at the time? \_\_\_\_\_

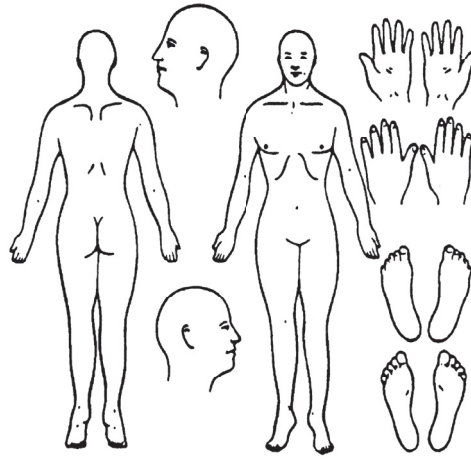
Please describe, in detail, how the accident happened: \_\_\_\_\_

\_\_\_\_\_

Please diagram the accident below:	Total number of vehicles involved in the collision: _____
	Total number of impacts to your vehicle: _____
	Side(s) of your vehicle impacted: _____
	Were you wearing a lap & shoulder belt? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Was there a head restraint? <input type="checkbox"/> Yes <input type="checkbox"/> No
	At impact, was head forward of head restraint? <input type="checkbox"/> Yes <input type="checkbox"/> No
	At impact, was your head rotated? <input type="checkbox"/> Yes <input type="checkbox"/> No
	At impact, was your torso rotated? <input type="checkbox"/> Yes <input type="checkbox"/> No
	At impact, was your body leaning forward? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Did you anticipate the impact? <input type="checkbox"/> Yes <input type="checkbox"/> No
Estimated speed of YOUR vehicle at impact: _____ mph	
Estimated speed of OTHER vehicle at impact: _____ mph	

Did you strike anything within the vehicle?  Yes  No If yes, please identify the item struck in the vehicle from the list below. Also, please draw a line from the item impacted to the part of the body struck.

- Airbag
- Dashboard
- Windshield
- Steering wheel
- Gear selector
- Head restraint
- Inner door panel
- Ceiling
- Armrest
- \_\_\_\_\_
- \_\_\_\_\_



Comments

Did the seat you were in break and/or fall backwards from the impact?  Yes  No Explain: \_\_\_\_\_

Did any windows break in your vehicle?  Yes  No If yes, please identify: \_\_\_\_\_

Was there any "flying" glass from the impact?  Yes  No If yes, please identify: \_\_\_\_\_

Were there any: Cuts?  Yes  No / Bruises?  Yes  No / Abrasions?  Yes  No / Photos taken?  Yes  No

If yes, please describe: \_\_\_\_\_

Make and model of the vehicle you were in: \_\_\_\_\_ Year: \_\_\_\_\_

Describe any damage done to the vehicle you were in: \_\_\_\_\_

Photos taken?  Yes  No

Make and model of the other vehicle(s): \_\_\_\_\_ Year: \_\_\_\_\_

Describe any damage done to the other vehicle(s): \_\_\_\_\_

Photos taken?  Yes  No

**After impact, did you:** lose consciousness at any time?  Yes  No \_\_\_\_\_

lose bowel or bladder control?  Yes  No \_\_\_\_\_

have facial numbness/speech problems?  Yes  No \_\_\_\_\_

extremity numbness/weakness?  Yes  No \_\_\_\_\_

Were you able to get out of the vehicle on your own?  Yes  No If not, who helped you? \_\_\_\_\_

If you were assisted out of your vehicle, describe how you were removed: \_\_\_\_\_

Did you receive any first aid at the scene?  Yes  No If yes, by whom? \_\_\_\_\_

If applicable, what first aid was provided to you at the scene? \_\_\_\_\_

Who was called or came to the accident scene?  Highway Patrol  Local Police  Sheriff  Paramedics

Ambulance  Other \_\_\_\_\_

Was a report made?  Yes  No If yes, do you have a copy?  Yes  No  Not yet, but I will provide it.

Did you go to the emergency room?  Yes  No Urgent care?  Yes  No Doctor's office?  Yes  No  
If you answered "yes" to any of the above questions, please identify where you went and who attended you there: \_\_\_\_\_

What was done for you there? Exam:  Yes  No Pain medication:  Yes  No  
X-ray:  Yes  No Anti-inflammatories:  Yes  No  
MRI:  Yes  No Muscle relaxants:  Yes  No  
CT:  Yes  No Supports/Braces:  Yes  No

What diagnoses were you given? \_\_\_\_\_

Were you told to do anything by the attending doctor?  Yes  No If yes, please identify: \_\_\_\_\_

Were you hospitalized at any time as a result of the injuries you sustained from the accident?  Yes  No If yes, please identify the name and location of the hospital, entry date, exit date, and the name of the treating doctor(s): \_\_\_\_\_

What was done for you at the hospital? \_\_\_\_\_

Describe symptoms: Immediately after the accident: \_\_\_\_\_

Later that same day: \_\_\_\_\_

The next day: \_\_\_\_\_

Have you seen any other health care professional since the first day of the accident?  Yes  No If yes, please complete the section below: *(Begin with the person you saw first and proceed to the most recent.)*

Name	Title	Dates seen	What was done for you?

Please identify any other treatment for this injury (check all that apply): *(specify)*

- Heat  Slept in different position  Restricted home activities: \_\_\_\_\_
- Cold  Slept on a different surface \_\_\_\_\_
- Rest  Minimized motions of the head  Restricted work activities: \_\_\_\_\_
- Exercise  Minimized overhead work \_\_\_\_\_
- Stretches  Minimized lifting  Continued prescription meds: \_\_\_\_\_
- Massage  Minimized sitting  Took over-the-counter meds: \_\_\_\_\_
- Other: \_\_\_\_\_

Normal job duties: \_\_\_\_\_

Current job duties: \_\_\_\_\_

Have you missed any work and/or job opportunities as a result of your auto accident?  Yes  No Please identify: \_\_\_\_\_

Have you had any injury or significant illness *since* the auto injury?  Yes  No If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

Have you had any significant injury or illness, of any type, *prior* to the auto injury?  Yes  No If yes, what was the nature of the problem and when did it occur? \_\_\_\_\_  
\_\_\_\_\_

If professional care was rendered for the above prior injury or condition, how long were you treated, by whom, and what was done for you? Was it fully resolved? \_\_\_\_\_  
\_\_\_\_\_

Have you ever had any award of permanent disability/impairment for any prior condition/injury?  Yes  No If yes, please identify what the award was, when it was received, and for what condition/injury: \_\_\_\_\_  
\_\_\_\_\_

Are you currently under any other doctor's care?  Yes  No If yes, who is the doctor and what is he/she treating you for? \_\_\_\_\_  
\_\_\_\_\_

What medications, prescribed or not, are you currently taking to treat any condition or injury *unrelated* to your auto accident injuries? \_\_\_\_\_  
\_\_\_\_\_

Have you ever served in the armed forces?  Yes  No If yes, what were the dates of service and what type of discharge did you receive? \_\_\_\_\_  
\_\_\_\_\_

Prior to this auto accident, have you ever been diagnosed as having any of the following? Circle *all* that apply.

- |              |                 |                   |                       |                           |
|--------------|-----------------|-------------------|-----------------------|---------------------------|
| Whiplash     | Neck Sprain     | Spondylolysis     | Vertebral Fracture    | Rheumatoid Arthritis      |
| Scoliosis    | Back Sprain     | Facet Arthrosis   | Metabolic Disorder    | Ankylosing Spondylitis    |
| Spondylosis  | Osteoporosis    | Disc Protrusion   | Diabetes Type 1 or 2  | Foraminal Encroachment    |
| Fibromyalgia | Pagets Disease  | Spinal Infection  | Any Spinal Anomaly    | Carpal Tunnel Syndrome    |
| TMJ Problem  | Spinal Stenosis | Spondylolisthesis | Extremity Dislocation | Degenerative Disc Disease |

Comments: \_\_\_\_\_  
\_\_\_\_\_

Before the auto accident, how would you rate your overall health?  Excellent  Good  Fair  Poor

Do you currently use tobacco products?  Yes  No If yes, how much do you smoke per day? \_\_\_\_\_

Do you currently drink alcohol?  Yes  No If yes, how much and how often? \_\_\_\_\_

Did you have any recreational activities or hobbies before the accident?  Yes  No If yes, what were they and how often did you do them? \_\_\_\_\_  
\_\_\_\_\_

Please provide any additional information you believe is important to your case: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

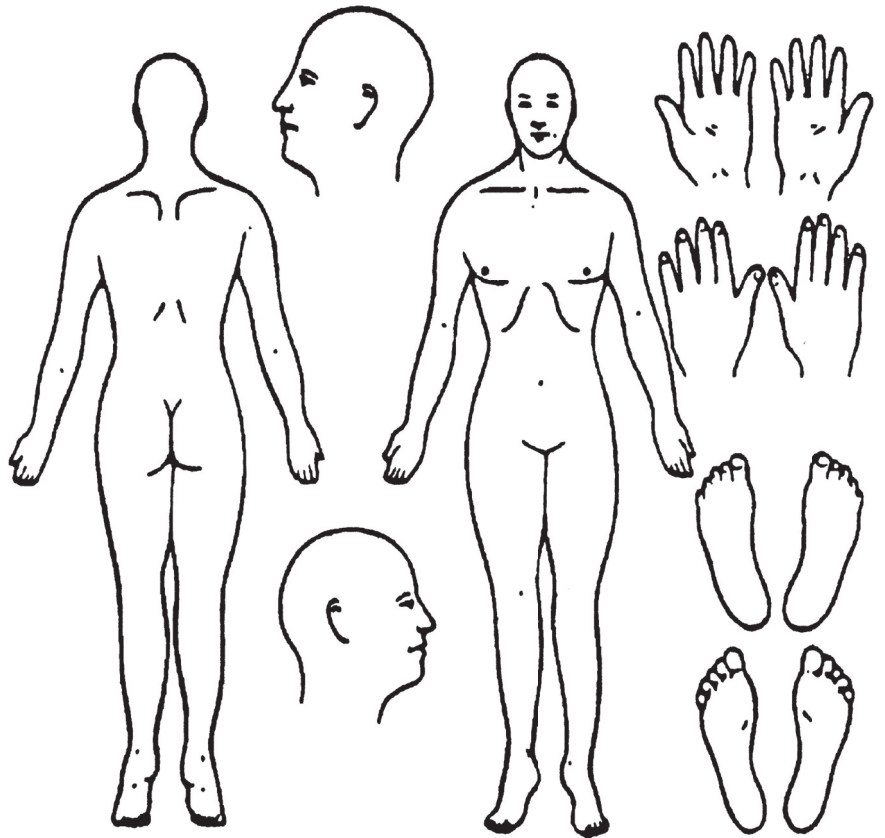
### Current Medical Complaints

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It is important to carefully identify your current complaints. Use the body diagram to identify the location and nature of your symptoms. **Please use the key below.**

- +++ = sharp or stabbing
- ~ = burning
- ooo = pins and needles
- vvv = dull or aching
- /// = numbness

-- Comments --



**--- Circle the number of any and all symptoms that have appeared, even briefly, since the time of the auto collision.---**

- |   |   |   |
|---|---|---|
| <ul style="list-style-type: none"> <li>1. Nausea</li> <li>2. Vertigo/dizziness/lightheadedness</li> <li>3. Neck pain/stiffness</li> <li>4. Headache</li> <li>5. Photophobia (sensitivity to light)</li> <li>6. Phonophobia (sensitivity to loud noises)</li> <li>7. Tinnitus (ringing in the ears)</li> <li>8. Impaired memory</li> <li>9. Difficulty concentrating</li> <li>10. Impaired comprehension or awareness</li> <li>11. Prolonged, unexplained staring</li> <li>12. A feeling of having a "brain fog"</li> <li>13. Forgetfulness</li> <li>14. Impaired logical thinking</li> <li>15. Difficulty with new or abstract concepts</li> <li>16. Insomnia (difficulty sleeping)</li> <li>17. Fatigue</li> <li>18. Apathy</li> <li>19. Outburst of anger</li> <li>20. Mood swings</li> <li>21. Depression</li> <li>22. Loss of libido (sex drive)</li> <li>23. Personality change</li> <li>24. Intolerance to alcohol</li> </ul> | <ul style="list-style-type: none"> <li>25. Clicking in the jaw</li> <li>26. Popping in the jaw</li> <li>27. Locking of the jaw</li> <li>28. Side shift of the jaw upon opening</li> <li>29. Inability to open the mouth wide</li> <li>30. Pain on chewing</li> <li>31. Facial pain</li> <li>32. Grinding your teeth</li> <li>33. Jaw muscles sore upon waking</li> <li>34. Chewing on one side of your mouth</li> <li>35. Painful teeth</li> <li>36. Loose or chipped teeth</li> <li>37. Tender muscles in front of the neck</li> </ul> | <ul style="list-style-type: none"> <li>47. Loss of weight</li> <li>48. Weight gain</li> <li>49. Nightmares</li> <li>50. Pain on inhaling deeply</li> <li>51. Indigestion</li> <li>52. Diarrhea</li> <li>53. Constipation</li> <li>54. Vomiting</li> <li>55. Nervousness</li> <li>56. Cramping</li> <li>57. Knees buckling unexpectedly</li> <li>58. Dropping things easily</li> <li>59. Weakness in the arms or legs</li> </ul> |
|---|---|---|
- Other Symptoms and/or Comments:*

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