-- Auto Accident Information --

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.	_____	_____	_____	☐ Yes ☐ No ☐ Unsure
2.	_____	_____	_____	☐ Yes ☐ No ☐ Unsure
3.	_____	_____	_____	☐ Yes ☐ No ☐ Unsure
4.	_____	_____	_____	☐ Yes ☐ No ☐ 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. Be sure to indicate which vehicle you were in. Feel free to use arrows and lines as needed.

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? ☐ Yes ☐ No

Was there a head restraint? ☐ Yes ☐ No

At impact, was head forward of head restraint? ☐ Yes ☐ No

At impact, was your head rotated? ☐ Yes ☐ No

At impact, was your torso rotated? ☐ Yes ☐ No

At impact, was your body leaning forward? ☐ Yes ☐ No

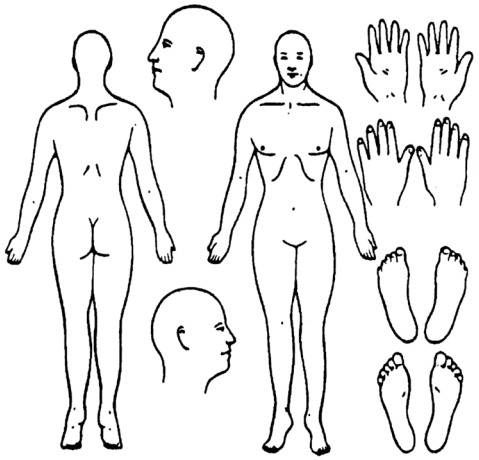
Did you anticipate the impact? ☐ Yes ☐ No

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
- ☐ Cold
- ☐ Rest
- ☐ Exercise
- ☐ Stretches
- ☐ Massage
- ☐ Slept in different position
- ☐ Slept on a different surface
- ☐ Minimized motions of the head
- ☐ Minimized overhead work
- ☐ Minimized lifting
- ☐ Minimized sitting
- ☐ Restricted home activities: _____
- ☐ Restricted work activities: _____
- ☐ Continued prescription meds: _____
- ☐ 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: _____

_____

_____

_____

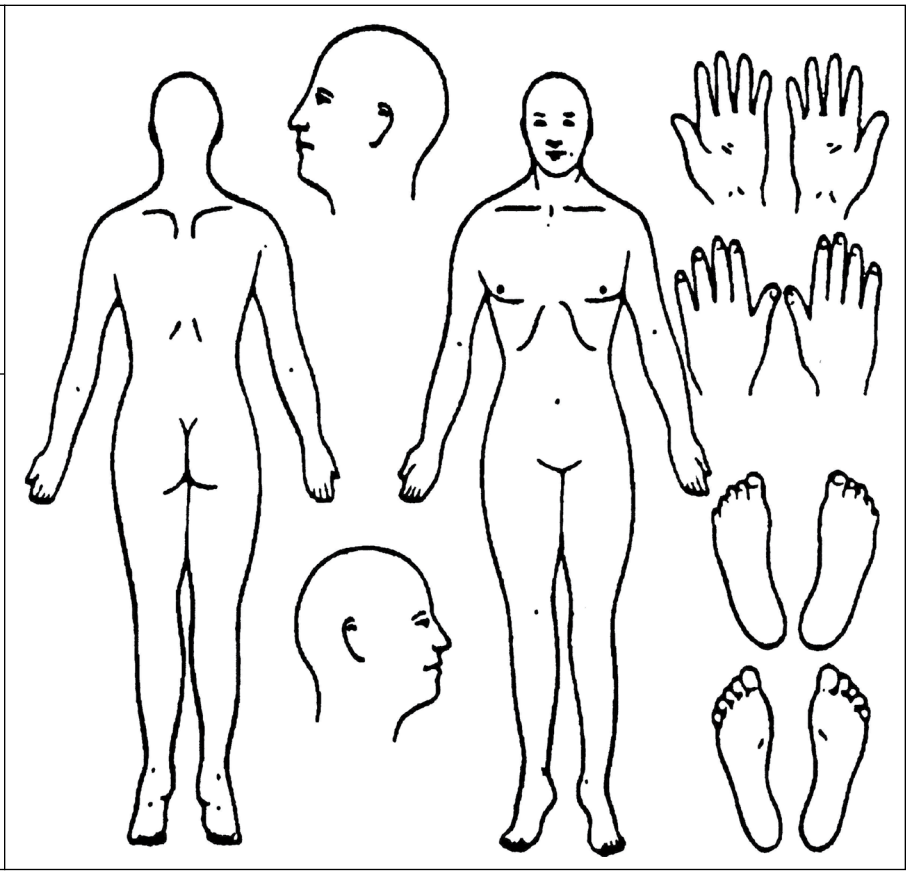
_____

Current Medical Complaints

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.---

1. Nausea
2. Vertigo/dizziness/lightheadedness
3. Neck pain/stiffness
4. Headache
5. Photophobia (sensitivity to light)
6. Phonophobia (sensitivity to loud noises)
7. Tinnitus (ringing in the ears)
8. Impaired memory
9. Difficulty concentrating
10. Impaired comprehension or awareness
11. Prolonged, unexplained staring
12. A feeling of having a "brain fog"
13. Forgetfulness
14. Impaired logical thinking
15. Difficulty with new or abstract concepts
16. Insomnia (difficulty sleeping)
17. Fatigue
18. Apathy
19. Outburst of anger
20. Mood swings
21. Depression
22. Loss of libido (sex drive)
23. Personality change
24. Intolerance to alcohol
25. Clicking in the jaw
26. Popping in the jaw
27. Locking of the jaw
28. Side shift of the jaw upon opening
29. Inability to open the mouth wide
30. Pain on chewing
31. Facial pain
32. Grinding your teeth
33. Jaw muscles sore upon waking
34. Chewing on one side of your mouth
35. Painful teeth
36. Loose or chipped teeth
37. Tender muscles in front of the neck
38. Pain on swallowing
39. Difficulty swallowing
40. Intolerance to strong odors
41. Decreased ability to smell
42. Decreased ability to taste
43. Vision changes
44. Blood in the urine
45. Pain over one or both kidneys
46. Urinary problems
47. Loss of weight
48. Weight gain
49. Nightmares
50. Pain on inhaling deeply
51. Indigestion
52. Diarrhea
53. Constipation
54. Vomiting
55. Nervousness
56. Cramping
57. Knees buckling unexpectedly
58. Dropping things easily
59. Weakness in the arms or legs

Other Symptoms and/or Comments:

_____

_____

_____

_____

_____

_____

Please sign and date this 5-page form here: Signature: _____ ***Date:*** _____