

**Please Fill Out This Form Completely and Legibly. Leave Nothing Blank.
If Something Does Not Apply, Write "N/A" on the Line.**

Name _____ Date of Birth _____ Today's Date _____

Date of Accident _____ Time of Accident _____

Your Vehicle:

Year _____ Make _____ Model _____

Your Speed _____ Damage to Vehicle \$ _____

Your Insurance Co. _____

Insurance Agent _____

Policy Number _____

Have You Retained an Attorney? Yes No If Yes, Attorney's Name _____

Attorney's Phone _____ Attorney's Address _____

Describe How the Accident Happened: _____

Accident Specifics (Check All That Apply):

You Were the: Driver Passenger

In a: Two Door Coupe Four Door Sedan SUV Pick Up

Motorcycle Other _____

Sitting in the: Front Seat Back Seat

Wearing: Seat Belt No Seat Belt Helmet No Helmet

You Were Heading: North South East West

Name of Street or Highway: _____

Other Vehicle was Heading: North South East West

Name of Street or Highway: _____

The Road Was: Dry Wet Icy Snowy

The Weather Conditions: Sunny Cloudy Foggy Snowing

Light Rain Heavy Rain

Impending Collision: Aware Unaware Braced Not Braced

Were You Struck From: Behind Front Left Side Right Side

Did Your Head: Strike Object Not Strike Object Break Glass

In Relation to the Back of Your Head, Was Your Headrest Set: Low Middle High

Where Was Your Head Facing at the Time of Impact? Left Forward Right

Were You Leaning Forward at the Time of Impact? Yes No

Did You Experience: Shock Flash of Light Seen Loss of Consciousness

Air Bag Deployed? Yes No

Were the Police Notified? Yes No

**Please Fill Out This Form Completely and Legibly. Leave Nothing Blank.
If Something Does Not Apply, Write "N/A" on the Line.**

Immediately Following the Accident: Ambulance (Paramedics Called) Treated at Scene
 Transported to Hospital By Ambulance Went to Hospital on Own
 Diagnostics Performed at Hospital Treatment at Hospital
 Medication Prescribed, _____ Follow Up Recommended

State Your Emotions and Physical State **Immediately** Following the Accident: _____

State Your Emotions and Physical State **After the First Few Days:** _____

Other Doctors Seen: Orthopedist, Name _____
Diagnosis _____ Treatment _____
 Neurologist, Name _____
Diagnosis _____ Treatment _____
 Massage Therapist, Name _____
Diagnosis _____ Treatment _____
 Physical Therapist, Name _____
Diagnosis _____ Treatment _____
 Psychiatrist, Name _____
Diagnosis _____ Treatment _____
 Other, Name _____
Diagnosis _____ Treatment _____

Pain Characteristics for the Major Area of Complaint:

The Pain Started _____

The Pain is Made Better By _____

The Pain is Made Worse By _____

The Pain Has the Following Qualities:

There Is There Is Not Radiation Into _____
 There Is There Is Not Referred Pain Into _____
 There Is There Is Not Parasthesia (Tingling/Numbness) Into _____

The Pain is Located _____

The Pain is (as Far as Timing is Concerned: i.e. Comes and Goes, Constant, etc...) _____

Have You Ever Had Any Complaints in the Involved Area Before? Yes No

If Yes, What Were the Complaints? _____

Before the Injury, Were You Capable of Working on an Equal Basis with Others Your Age? Yes No

Are Your Work Activities Restricted as a Result of This Accident? Yes No

Since This Injury, Are Your Symptoms: Improving Getting Worse The Same