Please hand the police report with your photo ID to receptionist

Name _____ Date:_____

Address_____

Date of Birth _____ Male Female

Home Phone #_____
Work Phone #_____
Cell Phone #_____

Date of Accident_____

How did the accident happen?
_____

Were you the Driver ? Yes No Were you a passenger? Yes or No

How many people were in the car? _____

What type of car were you driving or a passenger in at time of accident?

Make _____ Model_____ Year_____

Type of other driver's vehicle(s)? car, van, truck _____

What type of damage was done to your vehicle?_____
_____
Estimate cost of repair? $_____

What type of damage was done to the other vehicle?_____
_____
Estimate cost of repair? $_____

Were your hands on the steering wheel?
Left, Right, Both hands

Did your vehicle get struck from the? front, back, left side, right side

What was the speed of your vehicle? _____ miles per hour

What was the speed of other vehicle ? _____ miles per hour
When was your headrest positioned? High or middle of head or lower part of head

Did your vehicle strike another vehicle or object? Yes No
If yes, front, back, left side, right side, roof.
When the accident occurred was it? Day night dawn dusk
Was road wet (raining, snowing, ice)? Yes No
How was the visibility? good or impaired

Were you wearing a seat belt? Yes No
Did it Break? Yes No
Did Airbag Deploy? Yes No
Were you aware that the impact was coming? Yes No
How was your head facing at impact? Straight, Left, Right

Did you strike the steering wheel? Yes No
What part of your body?_____

Did you strike the Windshield? Yes No
What part of your body?_____

Did you strike the driver's door? Yes No
What part of your body?_____

Did you strike the passenger door? Yes No
What part of your body?_____

Did you strike the driver's window? Yes No
What part of your body?_____

Did you strike the passenger window? Yes No
What part of your body?_____

Did you strike the roof? Yes No
What part of your body?_____

Did you strike the dashboard? Yes No
What part of your body?_____

Other? _____

Did you lose consciousness? Yes No
Get dizzy, nausea, headache? Yes No

Any other complaints as a **result of this accident** such as neck, low back, knee pain, etc….?

_____
_____
_____
_____
_____
_____

What complaints have you had **before** this accident?

_____
_____
_____
_____
_____
_____

Did you go to the hospital? Immediately or how many days later_____

Which hospital? _____

Transported by: Ambulance Private Transportation Drove Self
Did you break any bones? _____

_____

Did you have Bruises or Cuts? Where?

_____

What care did the Hospital provide?

_____

_____

Were X-rays or MRI's taken? _____

Have you seen any Doctors as a result of this Accident?

_____
_____
_____

What type of treatment or Medications are you taking as a result of this accident?

_____
_____
_____

Since the accident do you have?

nervousness anxiety fear of driving depression nightmares loss of concentration Jaw clenching

How many days of work have you missed?_____

Name of your insurance company?_____

Address_____

Phone #_____

Name of adjustor:_____

Claim #_____

Phone #_____

Name of your Attorney?_____

Address_____

Phone #_____

Complaints since the Accident:

Presenting Pain Pattern	
Place an "X" on the drawing below on areas causing pain and a letter describing it	A=Ache B=Burning S=Stabbing N=Numbness P= Pines & Needles

Neck Pain? Yes No

Pain scale(1-mild 5- moderate 10-extreme) circle one **1 2 3 4 5 6 7 8 9 10** Percent with pain?**25 50 75 100**
Quality (Circle all that apply) Sharp, Dull, Ache, Burning, Stabbing, Numbing, Tingling, Weakness?

Radiates to (Circle all that apply) Left or right shoulder, Left or right elbow, Left or right hand,

Aggravated by? (Circle all that apply) Walking, sitting, standing, Lying, bending, lifting, grabbing, reading?

Relieved by? (Circle all that apply) Walking, sitting, standing, Lying,?

Timing? (Circle all that apply) Wake up with pain, at end of day, during sleep?

Low Back Pain? Yes No

Pain scale(1-mild 5- moderate 10-extreme) circle one **1 2 3 4 5 6 7 8 9 10** Percent with pain?**25 50 75 100**
Quality (Circle all that apply) Sharp, Dull, Ache, Burning, Stabbing, Numbing, Tingling, Weakness?

Radiates to (Circle all that apply) Left or right buttock, Left or right leg, Left or right knee, Left or right foot,

Aggravated by? (Circle all that apply) Walking, sitting, standing, Lying, bending, lifting, ?
_____
Relieved by? (Circle all that apply) Walking, sitting, standing, Lying,?
_____
Timing? (Circle all that apply) Wake up with pain, at end of day, during sleep?
_____

Headaches Yes No Left Right (1-10___ % _____) _____
Dizziness Yes No **Loss of balance** Yes No _____

Shoulder Pain Yes No Left Right (1-10___ % _____) _____
Elbow Pain Yes No Left Right (1-10___ % _____) _____
Wrist Pain Yes No Left Right (1-10___ % _____) _____
Jaw Pain Yes No Left Right (1-10___ % _____) _____
Hip Pain Yes No Left Right (1-10___ % _____) _____
Knee Pain Yes No Left Right (1-10___ % _____) _____
Foot Pain Yes No Left Right (1-10___ % _____) _____

Patient Name:_____ Sign_____
Doctors Name:_____ Sign_____
Date:_____