1. Auto Accident / Slip and Fall

Date of Accident: ___________Location/Time: ____________________Your vehicle make?_______________

Your Auto Insurance Information:
Name of Insurance Company__________________________ Phone # _________________________________
Claim # _______________________________________ Policy # ________________________________
Name of Policy Holder ___________________________ Adjuster's Name ____________________________

Party at Fault Information:
Name of Person at Fault _______________________________
Name of Insurance ___________________________________ Phone # _______________________________
Claim # ____Policy # _______________________________
Name of Policy Holder ______ _____________________Adjuster's Name______________________________

Your Health Ins. Name: _____________________________ ID # __________________________________
Group # ______________________________________Insurance Phone #______________________________

Accident Questionnaire:

1. Were you ( ) Driver, ( ) Front Passenger, ( ) Rear passenger, ( ) Other __________________
2. Number of people in vehicle? ________ Were you wearing seat belt? ( ) Yes, ( ) No
3. Were you looking? ( ) straight ahead, ( ) to the left, ( ) to the right, ( ) Other ______________
4. Were you hit from?( ) Front, ( ) Behind, ( ) Left Side, ( ) Right Side, ( ) Other ___________
5. At the time of the accident was your vehicle: ( ) in motion, ( ) stopped, ( ) Other ____________
6. At the time of impact were you thrown? ( ) forward, ( ) backward, ( ) side to side
7. Did your body strike against anything in the vehicle? ( ) Yes, ( ) No, ( ) Don't remember
   If yes, describe: ____
8. Were the police notified? ( ) Yes, ( ) No
9. In your own words, please describe the accident:
   ____
   ____
10. Did you have any pain immediately after the accident? ( ) Yes, ( ) No
    If yes, Where? ____
    If no, when did you start having pain and where? _____________________________________
11. Were you knocked unconscious? ( ) Yes, ( ) No
12. Did you receive any cuts/bruises? ( ) Yes ________________, ( ) No
13. Were you taken from the scene of the accident to? ( ) Hospital, ( ) Home, ( ) Other ________
    If you went to a hospital on a later date, when? ______________________________________
    Hospital's Name?__________________________ Released Date ?________________________
14. Have you been treated by any other doctor since the accident? ( ) Yes, ( ) No
    If yes, please list doctor's name and phone number(s)?
    ____
15. Have you lost any time from work as a result of this accident? ( ) Yes, ( ) No
    If yes, please provide the dates? ____
16. Have you ever been involved in an auto accident before? ( ) Yes, ( ) No
    If yes, were you injured?( ) No, ( ) Yes
    If yes, describe your previous bodily injuries? ____

Current Symptoms Since the Accident:

☐ Dizziness ☐ Hip Pain ☐ Urinary / Bowel difficulty

□ Headaches
□ Neck Pain
□ Upper back pain
□ Mid back pain
□ Low back pain
□ Chest pain
□ Rib pain
□ Shoulder pain
□ Arm pain
□ Elbow pain
□ Forearm
□ Wrist pain
□ Hand / finger pain

□ Thigh Pain
□ Knee pain
□ Ankle pain
□ Leg pain
□ Foot pain
□ Numbness
□ Tingling
□ Blurred vision
□ Fatigue
□ Fever / Infection
□ Ringing / Pain in ears
□ Difficulty eating
□ Abdominal Pain

□ Nausea / Vomiting
□ Nervousness
□ Sleeping Problems
□ Constant irritability
□ Loss of memory
□ Loss of balance
□ Jaw pain
□ Other ______________________

Slip and Fall

How did you get injury?
____
____

Attorney Information:

Name _______________________________ Phone # _____________________Fax # ________________________
Address ____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status.

____ ___________________
Signature of Patient or Parent/Guardian of Minor Today's Date