



PERSONAL INJURY INFORMATION

Name _____ Date __ / __ / __ Phone _____
 Address _____ City _____ State __ Zip _____
 Employer's Name _____
 Employer's Address _____

Your Ins. Co _____ Address _____
 Phone _____ Accident Claim # _____ Agent's Name _____
 Driver/Other Vehicle _____ Ins. Co. _____ Policy # _____
 Have you retained an attorney? () Yes () No Name _____
 Were there any witnesses? () Yes () No Name(s) _____

Nature of Accident

1. Date of accident _____ Time of day _____ Road Conditions _____
2. Were you: () Driver () Passenger () Front seat () Backseat
3. Number of people in your vehicle _____ Other vehicle _____
4. What direction were you headed? () North () East () South () West
5. On (name of street) _____
6. What direction was the other vehicle headed? () North () East () South () West
7. On (name of street) _____
8. Were you struck from behind, front, left side, right side
9. Were you knocked unconscious? () Yes () No If yes for how long _____
10. Were the police notified? () Yes () No
11. In your own words please describe the accident: _____

12. Did you have any physical complaints BEFORE THE ACCIDENT? () Yes () No If yes, please describe in detail

13. Do you have any congenital (from birth) factors which relate to this problem? () Yes () No If yes, please describe _____

14. Do you have any previous illnesses that relate to this case? () Yes () No If yes, please describe



- 15. Please describe how you felt
 - a. DURING the accident: _____
 - b. IMMEDIATELY AFTER the accident _____
 - c. LATER THAT DAY _____
 - d. THE NEXT DAY: _____
- 16. What are your present complaints and symptoms? _____
- 17. Where were you taken after the accident? _____
- 18. Have you been treated by another doctor since the accident? _____
- 19. What type of treatment did you receive? _____
- 20. Do you notice any activity restrictions as a result of this injury? () Yes () No. If yes, please describe in detail: _____

- 21. Since this injury occurred, are your symptoms: () improving () getting worse () same
- 22. Have you lost time from work as a result of this accident? () Yes () No If yes, please state the type of compensation you are receiving: _____
- 23. Have you ever been involved in an accident before? () yes () No If yes, please describe, including date(s) and type(s) of accidents as well as injury (ies) received: _____
- 24. Where were you taken after the accident? _____
- 25. Have you been treated by another doctor since the accident(s)? () Yes () No If yes, please list the doctor's name _____
- 26. What type of treatment(s) did you receive? _____

Patient Signature _____