Auto Injury Information

Name _____ Today's Date _____
Date of Accident _____ Time of Accident _____ AM PM
Location of Accident _____
Type of Accident: [ ] Auto/Traffic [ ] Work/On Job [ ] At Home [ ] Other _____
Describe how the accident happened in your own words: _____
_____
_____
_____

Name of Hospital: _____ Attended by Dr. _____
Were you x-rayed at the hospital? [ ] Yes [ ] No If so, what was the diagnosis? _____
Were you admitted to the hospital? [ ] Yes [ ] No How long did you stay? _____
What treatment was rendered? _____
What recommendations were made? _____
List any other doctors you have seen as a result of this accident: _____
_____

Have you lost any time from work because of this accident? [ ] Yes [ ] No If yes, give days of disability: _____
Totally disabled from _____ to _____ Partially disabled from _____ to _____
Have you returned to work since the accident? [ ] Yes [ ] No Were you wearing a seat belt? [ ] Yes [ ] No
What kind of vehicle hit yours? _____ What kind of vehicle were you in? _____
If auto accident, were you the [ ] Driver [ ] Passenger [ ] Pedestrian?
If passenger, were you sitting in the [ ] Front [ ] Right Rear [ ] Left Rear? [ ] Other ?_____
Did your vehicle hit other vehicle(s)? [ ] Yes [ ] No Estimated speed of your vehicle at impact? _____ MPH
Was your vehicle hit by another vehicle(s)? [ ] Yes [ ] No Estimated speed of other vehicle at impact? _____ MPH
Did your car strike the other(s) involved? [ ] Yes [ ] No or did the other car strike yours? [ ] Yes [ ] No [ ] Undetermined

VEHICLE YOU WERE IN:
Driver _____
Insured: _____
Address: _____
Phone: _____
Auto Insurance Co.: _____
Ins. Co. Address: _____
Adjuster: _____
Phone: _____
Policy #: _____
Claim # _____

OTHER VEHICLE
Driver: _____
Insured: _____
Address: _____
Phone: _____
Auto Insurance Co.: _____
Ins. Co. Address: _____
Adjuster: _____
Phone: _____
Policy #: _____
Claim # _____

Did you require post-accident hospitalization? [ ] Yes [ ] No

CHECK THE SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

[ ] Headache	[ ] Irritability	[ ] Numbness in toes	[ ] Face flushed	[ ] Feet cold
[ ] Neck pain	[ ] Chest pain	[ ] Shortness of breath	[ ] Buzzing in ears	[ ] Hands cold
[ ] Neck stiff	[ ] Dizziness	[ ] Fatigue	[ ] Loss of balance	[ ] Stomach upset
[ ] Sleeping problems	[ ] Head seems too heavy	[ ] Depression	[ ] Fainting spells	[ ] Constipation
[ ] Back pain	[ ] Pins & needles in Arms	[ ] Light bothers eyes	[ ] Loss of smell	[ ] Cold sweats
[ ] Nervousness	[ ] Pins & needles in Legs	[ ] Loss of memory	[ ] Loss of taste	[ ] Fever
[ ] Tension	[ ] Numbness in fingers	[ ] Ears ring	[ ] Diarrhea	[ ] _____

Symptoms other than above: _____
Have you lost days of work? [ ] YES [ ] NO Dates: _____
Name of your Insurance Company involved: _____
Name of person at your Insurance Company responsible for injuries: _____
Have you been contacted by an Insurance Adjuster or Company Representative regarding this claim? [ ] YES [ ] NO
Do you have an attorney who has advised you in this case? [ ] YES [ ] NO Name: _____
Address of Attorney: _____ Phone No: _____
Patient's Signature: _____ Date: _____