INNOVATIVE INJURY SOLUTIONS

Patient Name:_____ Today's Date:_____

Date of accident: _____ Where did the accident occur? City_____ State: _____

Where were you sitting?	Where was your car hit?	On which side was your car hit?
☐ Driver seat ☐ Front Right	☐ Rear-end ☐ Front-end	☐ Left side ☐ Right-side
☐ Rear Left ☐ Rear Right	☐ T-Bone ☐ Other	☐ Other

Did you lose consciousness? ☐ Yes ☐ No

Were you wearing a seatbelt? ☐ Yes ☐

No ☐ ☐

Did the Airbag deploy? Yes No

Have any X-rays/CT scans/MRIs been taken? ☐ Yes ☐

No

Did you receive a ticket? ☐ Yes ☐

No ☐ ☐

Did the other party receive a ticket? ☐ Yes ☐ No

Has liability been accepted by the at fault insurance: Yes No Pending

At fault driver name: _____At fault address: _____

At fault party Insurance Co: _____ Policy #: _____

At fault vehicle make/model: _____

What symptoms are you currently experiencing now from the accident? (Start with the worst complaint:

_____

What was your treatment **on the day** of the accident/injury?_____

What has been your treatment **since** the accident/injury?_____

Which doctors **have you seen** regarding this accident/injury?_____

Did any of your present symptoms exist before the accident? ☐ Yes ☐ No (If Yes, please describe)

_____

Have you received other treatments for these same areas in the past? ☐ Yes ☐ No

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If so, what were the treatments?_____

Do you think that these symptoms are directly related to the accident? ☐ Yes ☐ No

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