Patient Name: Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of accident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Where did the accident occur? City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_

**Where were you sitting?**

Driver seat

Front Right

Rear Left

Rear Right

**Where was your car hit?**

Rear-end

Front-end

T-Bone

Other

**On which side was your car hit?**

Left side

Right-side

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

 If so, what were the treatments?

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