IF YOU WERE INVOLVED IN AN AUTO TRAUMA, PLEASE FILL OUT THE FOLLOWING:

Patient Name: _____ Patient Account #:_____

Your Auto Insurance Company: _____CLAIM#:_____ PHONE#:_____

Other Drivers Insurance Company: _____CLAIM#:_____ PHONE#:_____

Date of Collision ____/____/____ Time of Accident ____:___ PM/AM Roads: ☐ Wet ☐ Dry ☐ Icy ☐ Other

Street, Highway or Intersection & City and State of Accident: _____

Police on the scene? ☐ Yes ☐ No / Accident Report filed? ☐ Yes ☐ No / Did you go to the Hospital? ☐ Yes ☐ No

If yes, how were you transported? ☐ Ambulance ☐ Friend ☐ Spouse ☐ Self / Previous treatment: ☐ Yes ☐ No

What is the name(s) of the facility? _____

Details of the examination/treatment: ☐ Exam ☐ Medication ☐ Physical Therapy ☐ Other_____

Diagnostic studies: ☐ X-rays: Area(s) _____ ☐ MRI: Area(s) _____ ☐ EMG: Area(s) _____

☐ CT: Area(s) _____ ☐ Ultrasound: Area(s) _____ ☐ MRI: Area(s) _____

☐ Other: Test? _____Area(s) _____

Did you have any: ☐ Cut(s) ☐ Bleeding ☐ Bruise(s) ☐ Abrasions / Location(s)_____

Were you surprised by the impact? ☐ Yes ☐ No / Did you lose consciousness? ☐ Yes ☐ No

Where were you in the vehicle? ☐ Driver ☐ Front Passenger ☐ Left Rear ☐ Right Rear ☐ Mid Front ☐ Mid Back

Seat Belt? ☐ Yes ☐ No / If yes: ☐ Lap belt only ☐ Shoulder lap belt ☐ Child seat belt / Injured from Belt? ☐ Yes ☐ No

Airbags deploy? ☐ Yes ☐ No / Which bags deployed: _____ Where were you hit by airbags: _____

Did your face, head, or chest hit: Wheel: ☐ Yes ☐ No Window: ☐ Yes ☐ No Windshield: ☐ Yes ☐ No Dash: ☐ Yes ☐ No

Did you impact the interior of the vehicle? ☐ Yes ☐ No / If yes, where? ☐ Head ☐ Chest ☐ R or L shoulder ☐ R or L arm ☐ R or L hip ☐ R or L leg

Your Vehicle: Year_____ Make_____ Model _____ / Were you Stopped? ☐ Yes ☐ No / Driver foot on the brake? ☐ Yes ☐ No

If you were not stopped, estimate speed: ____mph. If moving, your vehicle was: ☐ Slowing down ☐ Gaining Speed ☐ Steady Speed

How many people were in the Vehicle: _____ / Was the other vehicle moving? ☐ Yes ☐ No

If other vehicle was moving, was it: ☐ Slowing down ☐ Gaining Speed ☐ Steady Speed /Head pointed: ☐ Forward ☐ Left ☐ Right

The impact was: ☐ Rear end ☐ Diver side impact ☐ Passenger side impact ☐ Head on ☐ Oblique angle ☐ Side Swipe

☐ Roll over (Sideways) ☐ Roll over (End over end)

Were you off work from the accident? ☐ Yes ☐ No / If yes dates From _____ to _____ Physical work: ☐ Yes ☐ No

Does work aggravate your pain? ☐ Yes ☐ No / What parts of your vehicle broke? ☐ Windshield ☐ Steering wheel ☐ Driver side window ☐ Passenger side window ☐ Rear drives side window ☐ Rear passenger side window

Estimated Damage to your vehicle: $_____

Confidence you will heal completely: ☐ 0 ☐ 1☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Vehicle damage was ☐ mild ☐ moderate ☐ severe / Vehicle estimate ☐ less than $1,500 ☐ $1,500 to $3,500 ☐ over $3,500 ☐ totaled

Immediately following the accident, the problems (pains) were ☐ severe ☐ moderate ☐ mild ☐ absent

As time passed the problems (pains) ☐ worsened ☐ intensified ☐ stayed the same

IF YOU WERE INVOLVED IN A WORK-RELATED TRAUMA, PLEASE FILL OUT THE FOLLOWING:

Patient Name: _____ Patient Account #:_____

Employer Information: Name: _____ Phone #:_____

Occupation: _____ Job Description/Duties:_____

Did you notify the employer of the injury? □ Yes □ No

Employer Contact Name: _____ Phone #: _____ Fax #: _____

Work Comp Insurance Company: _____Claim #:_____ Phone #:_____

Injury Details (please describe): _____

_____

_____

_____

Did the employer refer you to a medical facility? □ Yes □ No

Additional information: If you were sent to a medical facility compete the following if known:

Name of Facility: _____ Address: _____ Phone: _____

Did you lose time from work? □ Yes □ No / If you were unable to work, what duties? (As many as apply) □ Lifting □ Sitting □ Bending □ Stooping □ Walking □ Pushing □ Unable to handle stress □ Other _____

Are you able to work part time? □ Yes □ No / Full time? □ Yes □ No