Name: ______________________________ Date of Birth: ____/____/____

History of Accident

Is your condition due to an: ❑ Auto Injury ❑Work Injury ❑ Slip and Fall ❑ Other Accident (describe below)

If Slip and Fall or Other Type of Injury, please describe: ______________________________

Worker's Comp Accident details: ______________________________

Have you retained an attorney for this accident? ❑ Yes ❑ No Name: ______________ Phone: ______________

Auto Accident Information

Date of Accident: ____/____/____ Time: ________ Type of Vehicle: Year ________ Make________ Model________

Were you the: ❑ Driver ❑ Passenger ❑Front ❑ Back Owner of the Vehicle: ______________

Were you restrained: ❑ Yes ❑ No Were you struck from: ❑ Front ❑ Back ❑ Left-side ❑ Right-side

Please describe your accident in detail: ______________________________

Did any part of your body strike the car? ❑Yes ❑ No Please explain: ______________________________

Were you knocked unconscious? ❑ Yes ❑ No Police Notified? ❑Yes ❑ No Ticket Issued? ❑Yes ❑No To whom? ________

Were you taken to the hospital? ❑Immediately ❑Later That Day ❑ Days later? ______ ❑ No other follow up

Name of Hospital: ______________ How did you get there? ❑Ambulance ❑Drove yourself ❑ Friend

X-rays/ CT Scan Performed? ❑Yes ❑No What areas? ________ Any other Testing? ________

Results or Diagnosis?______________________________

Medication? ❑Yes ❑No Names of Medication: ______________________________

Have you been treated by any other doctors as a results of this accident? ❑Yes ❑ No

Who and When? ______________ Testing performed? ______________

Have you missed work as a result of the accident? ❑Yes ❑No How many days? ______________

Please check the symptoms you have experienced since your accident:

❑Headaches ❑Dizziness ❑Depression ❑Neck Pain ❑Head too Heavy ❑Tension ❑Irritability ❑Fatigue

❑Neck Stiffness ❑Light bothers Eyes ❑Cold Sweats ❑Fever ❑Nervousness ❑Back Pain ❑Sleeping ❑Chest Pain

❑Ears Ringing ❑Face Flushed ❑Diarrhea ❑Memory Loss ❑Shortness of Breath ❑Loss of Balance ❑Fainting

❑Numbness fingers ❑Numbness toes ❑Pins/Needles Arms ❑Pins/Needles Legs

Prior to this incident, have you been involved in any other past Motor Vehicle Accidents: ❑ Yes ❑ No Date: ____/____/____

Did you experience any trauma? ❑Yes ❑No If so, what was your diagnosis:______________________________

Previous Settlement? ❑Yes ❑No Do you still experience symptoms from your prior accident: ❑Yes ❑ No

If yes, have the symptoms been exasperated by your most recent accident: ❑ Yes ❑ No