

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? _____

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

Auto Injury Information

CHECK THE SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

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

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: _____