PLEASE PRINT NEATLY AND COMPLETE THE ENTIRE FORM

Today's Date: _____

Your First Name: _____ MI:_____ Last Name: _____

Address: _____

City/State/Zip:_____

Home phone: (____)_____ Work phone: (____)_____ Ext _____

Cell phone: (___)_____

Social security number: _____ Birth date: _____

Sex: male ☐ female ☐ Marital status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Height: _____ Weight: _____ Children?_____how many?_____

INSURANCE INFORMATION:

Your Insurance Company Information:

Company Name: _____ Phone: (__)_____ Ext: _____

Claim number: _____Policy number: _____

Adjuster's Name: _____

PO Box/Street Number: _____

City/State/Zip:_____

Vehicle: Year: _____ Make: _____Model _____

Do you have personal injury protection (PIP) coverage? Yes ☐ No ☐ Don't know ☐
Does the driver of the vehicle you were in have PIP coverage? Yes ☐ No ☐ Don't know ☐

Insured's Insurance Information (If a passenger)

Insured's Name if other than patient?: _____ Phone: (___)_____

Company Name: _____Phone: (___)_____ Policy # : _____

PO Box/Street Number: _____

City/State/Zip: _____

Vehicle: Year: _____ Make: _____ Model _____

Other driver's Insurance Information

Other driver's Name (If another car was involved): _____ Phone: (___)_____

Company Name: _____ Phone: (___)_____ Ext: _____

PO Box/Street Number: _____

City/State/Zip: _____

Vehicle: Year: _____ Make: _____ Model _____

ATTORNEY INFORMATION

Today's Date:_____

Your First Name: _____ MI:_____ Last Name:_____

Have you retained an attorney? Yes ☐ No ☐

If yes, who? Name _____

Address _____ City _____ State_____ Zip_____

Telephone # (___)_____ Fax # (___)_____

CRASH REPORT

Were the police notified? Yes ☐ No ☐ Don't Know ☐

Did the police come to the scene? Yes ☐ No ☐ Don't Know ☐

Was a report filed? Yes ☐ No ☐ Don't Know ☐

Was the driver of your vehicle given a ticket by the police officer? Yes ☐ No ☐ Don't Know ☐

HISTORY OF OCCURRENCE

Date of Crash: _____ Time? _____ AM ☐ PM ☐

Driver of car: _____ Where were you seated? _____

Who owns the car? _____ Year and model car: _____

What was the approximate damage of the car you were in?: _____

Visibility at the time of the crash: POOR ☐ FAIR ☐ GOOD ☐

Light conditions: DAWN ☐ DAYLIGHT ☐ DUSK ☐ NIGHT/DARK ☐

Road conditions: DRY ☐ WET ☐ ICE ☐ GRAVEL ☐ OTHER ☐

Weather conditions: CLEAR ☐ RAIN ☐ FOG ☐ CLOUDY ☐ OVERCAST ☐ SNOW ☐ ICE ☐

Your car: Hit another car ☐ Was hit in the: Right ☐ Left ☐ Rear ☐ Front ☐ Side ☐

Type of Impact: Head-on collision ☐ Broad side-collision ☐ Rear-end collision ☐ Front impact, rearended car in front ☐ Non-collision ☐

Did you know the crash was about to happen? Yes ☐ No ☐

Did you brace for the impact? Yes ☐ No ☐

Head/body position at time of impact? Head turned: Right ☐ Left ☐ Head looking back ☐

Head looking forward ☐ Body straight in sitting position ☐ Body rotated ☐ Right ☐ Left ☐

Were you able to exit the car? Yes ☐ No ☐

Were you able to move all body parts? Yes ☐ No ☐ If no, what parts and why?

How many hands did you have on the steering wheel? ONE ☐ TWO ☐

Did you hit your head? Yes ☐ No ☐

Were you struck by an air bag? Yes ☐ No ☐

Were you hurt by the seatbelt? Yes ☐ No ☐

CRASH REPORT

Today's Date: _____

Your First Name: _____ MI:_____ Last Name:_____

What was the last thing you remember? _____

What was the next thing you remember? _____

Does your car have headrests? Yes ☐ No ☐

If yes,what was the position of the headrests compared to your head before the accident?

- ☐ Top of the headrest even with the bottom of head
- ☐ Top of the headrest even with top of head
- ☐ Top of headrest even with middle of neck

Were you wearing a seat belt? Yes ☐ No ☐ Did the vehicle have airbags? Yes ☐ No ☐

- ☐ LAP BELT
- ☐ SHOULDER BELT
- ☐ BOTH

Did the airbags deploy? Yes ☐ No ☐

At the time of impact, what parts of your head or body hit parts inside the vehicle? Explain:

_____

Was your car stopped at the time of impact? Yes ☐ No ☐

Was your car braking at the time of impact? Yes ☐ No ☐

If your vehicle was traveling, what was the estimated speed? _____ MPH

If your vehicle was moving at the time of impact, was it:

- ☐ SLOWING DOWN
- ☐ SPEEDING UP
- ☐ TRAVELING AT A STEADY RATE OF SPEED
- ☐ WAS YOUR FOOT ON THE BRAKE?

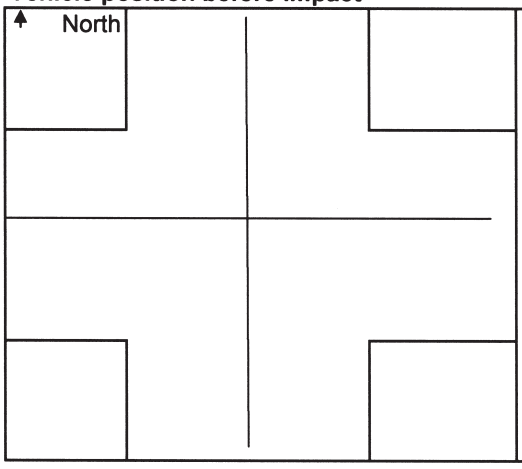
Briefly, describe any car parts that were damaged as a result of the crash:

_____

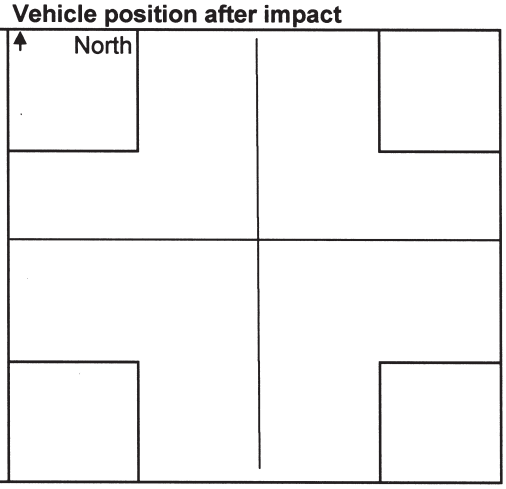
Were there any witnesses? Yes ☐ No ☐

Name: _____

Vehicle position before impact



Vehicle position after impact



Any other explanation below:

INJURIES / CARE PROVIDED

Today's Date: _____

Your First Name: _____ MI: _____ Last Name: _____

Did you receive emergency care at the accident site? Yes ☐ No ☐ Explain:

_____

Did you go to the E.R. or Urgent Care? Yes ☐ No ☐ Someone else drove me ☐
Ambulance ☐
Drove myself ☐
Police ☐

Were you examined? Yes ☐ No ☐ Were X-rays taken? Yes ☐ No ☐
Were you given treatment? Yes ☐ No ☐ MRI / CAT Scan Yes ☐ No ☐

If you were treated, what was the treatment given to you?

_____

Were you released with medication? What kind? _____

What benefits did you receive from the treatment?

_____

Date of last treatment? _____

What cuts or bruises did you sustain as a result of the crash?

_____

TIME LOSS / ACTIVITY RESTRICTIONS

Have you lost any time from work as a result of the crash? Yes ☐ No ☐

If yes, last day worked _____ Day returned to work _____

How many hours total? _____

Have you been released for work by a doctor? Yes ☐ No ☐

If yes, are you released with restrictions?

Describe: _____

Are you still on work restriction? Yes ☐ No ☐

Complaints/Symptoms: Come and go ☐ Came on gradually ☐ Came on suddenly ☐

Symptoms have persisted for: Hours ☐ Days ☐ Weeks ☐ Months ☐

Symptoms are **BETTER** in: AM ☐ Midday ☐ PM ☐

Symptoms are **WORSE** in: AM ☐ Midday ☐ PM ☐

Symptoms are present: With activity ☐ What percent of the day _____
All the time ☐

Other Symptoms: _____

Today's Date:_____

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X all that apply and put L = Left, R = Right, B = Both

Area of Pain:

Headache _____
Face Pain _____
Jaw Pain _____
Neck Pain _____
Shoulder _____
Arm Pain _____
Elbow _____
Wrist _____
Hand _____
Upper Back _____
Mid Back _____
Chest _____
Ribs _____
Low Back _____
Hips _____
Leg (s) _____
Knee _____
Ankle _____
Foot _____

Character of Symptoms:

Sore _____
Stiff _____
Tight _____
Ache _____
Cramping _____
Fatigue _____
Spasm _____
Sharp Pain _____
Tension _____
Radiating _____
Shooting _____
Burning _____
Dull Pain _____
Pain is in Spot _____
Pain is over area _____
Deep Pain _____
Tingling _____
Numbness _____

Other: _____

Pain Level:

Overall / All Together =_____

0= No Pain - 10 = Unbearable

Pain Frequency:

What percent of Day?
Day: _____ %

Functional Deficit: I feel _____ % functional.

Fear Avoidance Behaviors:
I avoid activities due to fear of pain or injury
Yes ☐ No ☐

Indicate Ability To Perform The Following Activities

Use codes : U - Unable P - Pain D - Difficult L - Limited N - Normal

Coughing or Sneezing _____
Kneeling _____
Balancing _____
Turning over in bed _____
Walking a short distance _____
Standing for more than 1hour _____
Sitting _____
Lying on back _____
lying flat on stomach _____
Knees bent _____
House work _____
Yard work _____
Childcare _____
Playing with kids _____
Work duties _____
Walking dog _____

Climbing _____
Getting out of the car _____
Bending _____
Getting dressed _____
Sleeping _____
Stooping _____
Gripping _____
Pushing _____
Pulling _____
Reaching _____
Bending _____
Lifting _____
Twisting _____
Moving from sit to stand _____
Driving _____
Sexual activity _____

Stairs _____
Keyboarding _____
Mousing _____
One position too long _____

Any other Comments or Considerations:

_____

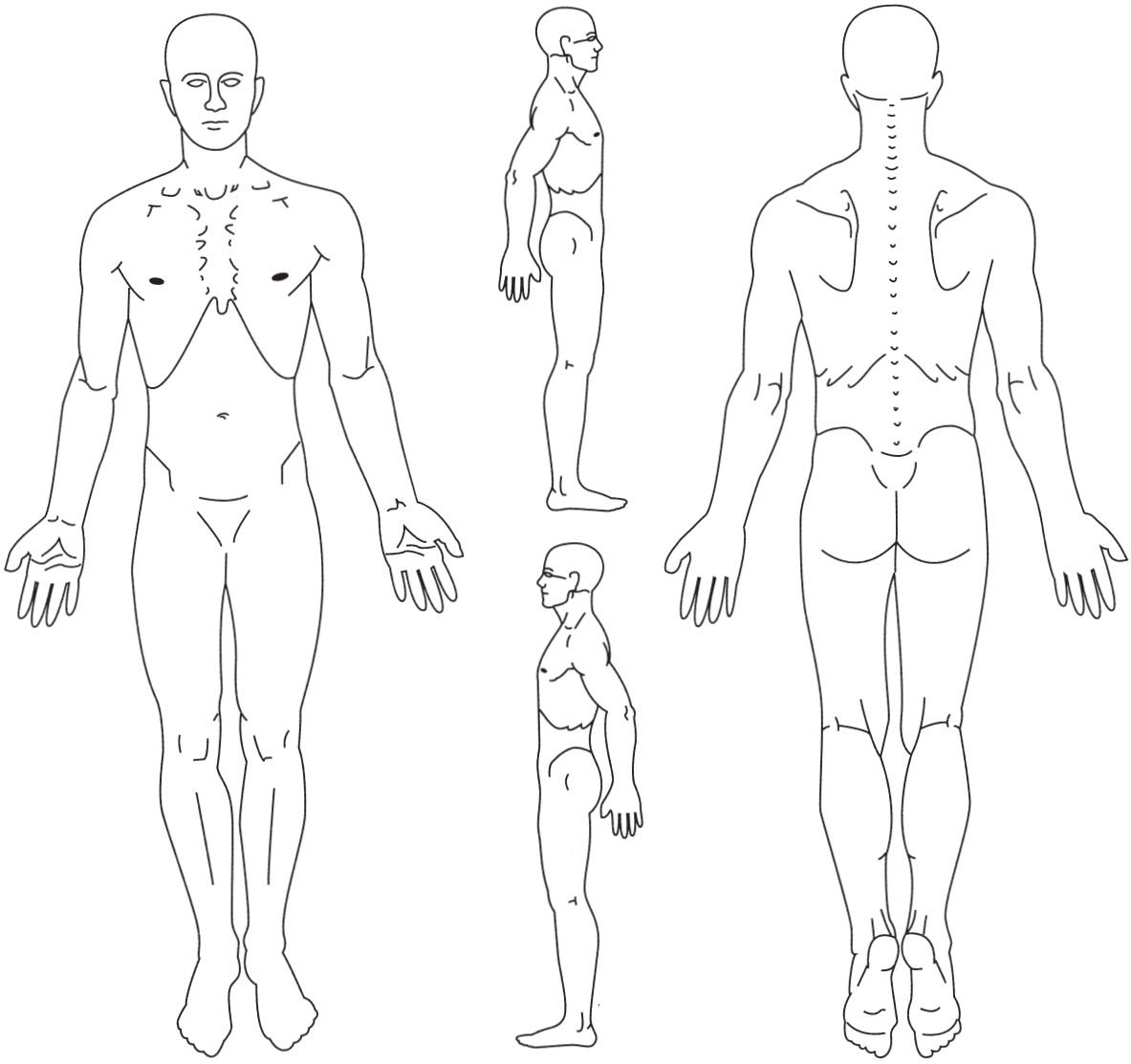
_____

Patient Name(Print) _____ Date _____

Patient ID # _____

Please draw the location of your pain or discomfort on the images below. Use the symbols shown to represent the type(s) of pain:

D = Dull
B = Burning
N = Numb
S = Stabbing/Cutting
T = Tingling (Pins & Needles)
C = Cramping



On the scales below, please draw a vertical line representing your pain or discomfort:

Rate the pain you have right **now:**

No Pain — Unbearable Pain

Rate your pain at its **best** in the past week:

No Pain — Unbearable Pain

Rate your **average** pain in the past week:

No Pain — Unbearable Pain

Rate your **worst** pain in the past week:

No Pain — Unbearable Pain