Auto Accident Information

Today's Date: _____ Date of Accident: _____

Patient Name: _____ Home #: _____

Address: _____ City: _____ Zip: _____

Birthdate: _____ Age: _____ Work #: _____

E-mail Address: _____ Cell #: _____

Emergency contact person: _____ Phone: _____

How were you referred to our office? _____

Your Auto Insurance Co: _____ Phone: _____

Policy #: _____ Med Pay Coverage Amount: _____

Claim #: _____ Date you made the claim: _____

Claims Address: _____

Adjuster Name: _____ Phone: _____

_____

Other Party's Name: _____

Address: _____ City: _____ Zip: _____

Birthdate: _____ Home Phone: _____ Cell: _____

Their Auto Insurance Co: _____

Policy #: _____

Claim #: _____ Date they made the claim: _____

Claims Address: _____

Adjuster Name: _____ Phone: _____

Auto Accident History

Patient Name: _____ Phone: _____

Date of Accident: _____ Time: _____

Driver of Car: _____ Who owns the car: _____

Where were you seated in the car when the accident occurred? _____

Passengers in your car: _____

Year & Model of your car: _____

Year & Model of the other car: _____

Approximate damage to your car= $_____ ❒ I Don't know yet- I'm getting an estimate

Visibility at time of the accident: ❒ Good ❒ Fair ❒ Poor ❒ Other _____

Road conditions at the time of the accident: ❒ Clear ❒ Dark ❒ Rainy ❒ Wet ❒ Icy

Type of accident: ❒ Rear-ended ❒ You hit the car in front ❒ Head-on collision

❒ Broad-side collision (driver side) ❒ Broad-side collision (passenger side) ❒ Side-swiped

Did you see the accident coming? ❒Yes ❒No Did you brace for impact? ❒Yes ❒No

Were you wearing your seatbelt and shoulder harness at the time of the accident? ❒Yes ❒No

What was the position of those headrests compared to your head before the accident?
❒ Top of headrest even with the bottom of your head
❒ Top of headrest even with the middle of your neck
❒ Top of headrest even with the top of your head
❒ My car does not come equipped with headrests

Was your head positioned: ❒ Straight Forward ❒ Turned to the left ❒ Turned to the right

Did any parts of your head or body hit the inside of the car: _____

Did the safety airbag inflate during the impact? ❒Yes (Front / Side) ❒No

Did you get any bleeding cuts as a result of the accident? ? ❒Yes ❒No Where? _____

Did you get any bruises as a result of the accident? ❒No ❒Yes- where: _____

Did the police make a report of the accident? ❒Yes ❒ No (If yes, please give us a copy)

*If no, did you exchange information with the other driver? ❒ Yes ❒No ❒ Hit & Run

As a result of the accident, were you: ❒ Shaken and/or shocked that the collision had occurred

❒Rendered almost unconscious ❒Rendered totally unconscious ❒Other:_____

Could you move all parts of your body after the collision? ❒Yes ❒No

If not, what parts couldn't you move?_____

Were you able to get out of the car and walk without help? ❒Yes ❒No

Describe how you felt after the accident

Immediately after the accident:_____

Later that day:_____

The next day:_____

When did you go to the hospital or urgent care center to get checked for your injuries? _____

How did you get to that facility? ❒Ambulance ❒Someone drove me there ❒I drove myself there

Name of Hospital:_____Location:_____

What treatment did you receive?_____

Did they do any special tests? ❒ X-Rays ❒ MRI ❒ CT Scan ❒ Blood

What other doctors have you seen for these injuries (besides at this office)?

Dr. Name:_____Date:_____

What treatment did you receive?_____

Did they do any special tests? ❒ X-Rays ❒ MRI ❒ CT Scan ❒ Blood

Any Other Doctors Seen:_____

Please list all medications you are presently taking, what they are for and how often you take them:

1._____

2. _____

3. _____

Your Occupation:_____Company:_____

Number of full days missed off work/school due to accident:_____

Number of part time days missed off work/school due to accident:_____

Please check any symptoms that you had since the accident:

❒ Neck pain/stiffness	❒ Headaches	❒ Dizziness/Loss of balance
❒ Midback pain/stiffness	❒ Nausea	❒ Ringing in the ears
❒ Lower back pain/stiffness	❒ Loss of Sleep	❒ Blurred vision
❒ Numbness in arms/hands	❒ Fatigue	❒ Shortness of breath
❒ Numbness in legs/feet	❒ Chest Pain	❒ Loss of senses of taste or smell
❒ Pain in shoulders	❒ Facial Pain	❒ Jaw pain / TMJ clicking
❒ Muscle Tension/Spasms	❒ Depression	❒ Anxiety/Irritability

Other symptoms: _____

Activities/Sports you cannot perform due to injuries: _____

_____

Neck Pain: _____

Describe how the neck pain feels: ❒ Sharp ❒ Dull ❒ Stiff ❒ Swollen

Do you have ❒Headaches ❒Numbness or Tingling in: ❒Shoulders ❒Arms ❒Hands

How often does the neck pain occur: ❒ Constant ❒ Comes and Goes _____

Is the neck pain: ❒ Improving ❒ Getting worse ❒ Staying the same

On a scale of 1-10, rate the severity of your neck pain:

(no pain) 1 2 3 4 5 6 7 8 9 10 (most severe)

What activities make the neck pain worse? _____

Does the neck pain interfere with your: ❒ Work ❒ Sleep ❒ Exercise ❒ Daily activities

Mid Back Pain: _____

Describe how the midback pain feels: ❒ Sharp ❒ Dull ❒ Stiff ❒ Swollen

Do you feel: ❒ Radiation of Pain Along the Ribs ❒ Sharp Chest Pain ❒ Dull Chest Pain

Is the pain: ❒ Constant ❒Comes&Goes ❒ Improving ❒ Getting worse ❒ Staying same

On a scale of 1-10, rate the severity of your midback pain:

(no pain) 1 2 3 4 5 6 7 8 9 10 (most severe)

What activities make the midback pain worse? _____

Does the midback pain interfere with your: ❒ Work ❒ Sleep ❒ Exercise ❒ Daily activities

Lower Back Pain:_____

Describe how the lower back pain feels: ❒ Sharp ❒ Dull ❒ Stiff ❒ Swollen

Do you feel: ❒ Radiation of pain _____ ❒ Numbness/Tingling _____

Is the pain: ❒ Constant ❒ Comes/Goes ❒ Improving ❒ Getting worse ❒ Staying the same

On a scale of 1-10, rate the severity of your lower back pain:

(no pain) 1 2 3 4 5 6 7 8 9 10 (most severe)

What activities make the lower back pain worse?_____

Does the low back pain interfere with your: ❒ Work ❒ Sleep ❒ Exercise ❒ Daily activities

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Other Complaint Area: _____

Describe how the pain feels: ❒ Sharp ❒ Dull ❒ Stiff ❒ Swollen ❒ Cramping

Is the pain: ❒ Constant ❒ Comes/Goes ❒ Improving ❒ Getting worse ❒ Staying same

On a scale of 1-10, rate the severity of your pain in this area:

(no pain) 1 2 3 4 5 6 7 8 9 10 (most severe)

What activities make the pain worse?_____

Does the pain interfere with your: ❒ Work ❒ Sleep ❒ Exercise ❒ Daily activities

Do you have any other complaints that are related to this accident? If so, please describe:

_____

Prior to this accident, have you ever had any of the physical complaints similar to what you have now?

❒Yes ❒No If yes, please describe:_____

_____

Have you had any serious injuries that required medical care? ❒Yes ❒No

Describe:_____

Have you had any serious illnesses that required hospitalization? ❒Yes ❒No

Describe:_____

Have you had any surgeries/broken bones? ❒Yes ❒No _____

List type of surgery and date: _____

Have you ever been diagnosed with any of these conditions? Please check all that apply:

❒ Cancer Type:_____ Treatment:_____

❒ Diabetes Type:_____ Treatment:_____

❒ Heart Problem:_____ Treatment:_____

❒ High Blood Pressure- Last known reading:_____

❒ Stroke ❒ Seizures ❒ Chest Pain ❒ Other_____

❒ Asthma _____ ❒ Allergies _____

❒ Digestive Problems_____ ❒ Heartburn ❒ Gas/Bloating ❒ Constipation/Diarrhea

❒ Recent Illness_____ ❒ Fever ❒ Nausea/Vomiting ❒ Dizziness

❒ Head injuries ❒ Concussion ❒ Knocked unconscious _____

❒ Spinal Arthritis Where:_____

❒ Disc Herniation- Where/When: _____

❒ Epidural Injection- Where/When: _____

❒ Any other spinal problems:_____

Are you pregnant? ❒Yes ❒No ❒Maybe- my last period was:_____

How would you like to pay for your care? ❒ Cash/check ❒ Credit Card ❒ Insurance

Do you have an attorney representing you for this accident? _____

Address: _____ City:_____ Zip:_____

Phone:_____Fax:_____

The above is accurate to the best of my knowledge _____
Signature

If the above information applies to your child, I fully authorize any doctor in this office to examine (including x-rays) and provide treatment to my child. _____
Signature

I acknowledge that I have received and read a copy of the Notice of Privacy Practices.

I give Dr. Rettig, Dr. Martin or Dr. Wintermute my authorization and consent to use and disclose my (or my child's) protected health care information for the purposes of treatment, payment and health care operations, as described in the Notice of Privacy Practices.

_____	_____	_____
Signature	**Print Name**	**Date**