A Healing Space

AUTO RELATED INJURY

Name_____ Today's Date: _____ / _____ / _____

Date of Accident: _____ / _____ / _____ Time of Accident:____ : _____ ☐ AM ☐ PM

Location of Accident: _____

Check Symptoms you have noticed since the accident:

☐ Headaches	☐ Sleeping Problems	☐ Lights Bother Eyes
☐ Neck Pain	☐ Head too Heavy	☐ Loss of Memory
☐ Diarrhea	☐ Feet Cold	☐ Neck Stiff
☐ Pins & Needles in Arms	☐ Ears Ringing	☐ Hands Cold
☐ Back Pain	☐ Pins & Needles in legs	☐ Dizziness
☐ Stomach Upset	☐ Numbness in Fingers	☐ Face Flushed
☐ Buzzing in Ears	☐ Nervousness	☐ Numbness in Toes
☐ Cold Sweat	☐ Constipation	☐ Loss of Balance
☐ Fainting	☐ Tension	☐ Fever
☐ Fatigue	☐ Shortness of Breath	☐ Irritability
☐ Depression	☐ Loss of Smell	☐ Chest Pain
☐ Loss of Taste	☐ Other _____	

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable	Painful
Lying on Back	☐	☐	☐
Lying on Side	☐	☐	☐
Lying on Stomach	☐	☐	☐
Sitting	☐	☐	☐
Standing	☐	☐	☐
Walking	☐	☐	☐
Running	☐	☐	☐
Lifting	☐	☐	☐
Working	☐	☐	☐
Bending	☐	☐	☐
Kneeling	☐	☐	☐
Pulling	☐	☐	☐
Reaching	☐	☐	☐

What is your Auto Insurance? _____ Phone:_____

Insurance Co. Address: _____

Who is the primary cardholder? _____ Phone:_____

Policy#: _____ Have you reported this to your Insurance Co.? ☐ Yes ☐ No

Claim #: _____ Does your Insurance Co. know you are coming here? ☐ Yes ☐ No

Other Parties Name: _____ Address: _____

Insurance Co.: _____ Policy#: _____

Address:_____

Adjuster: _____ Claim #: _____

Do you have an Attorney? ☐ Yes ☐ No, if yes, Who?_____ Phone: _____

PLEASE MARK WHEN APPROPRIATE:

Describe the circumstances of the accident: _____

_____

_____

Is your condition getting any worse? ☐ Yes ☐ No ☐ constant ☐ comes & goes

Did you require post-accident hospitalization? ☐ Yes ☐ No

Were you the ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Bicyclist?

Were you using a seat belt? ☐ Yes ☐ No.

Were you struck from ☐ Behind ☐ Right Side ☐ Left Side ☐ Front

Did your car strike the others involved? ☐ Yes ☐ No

What speed was your vehicle going at the time of collision? _____ mph

What speed was the other vehicle going at the time of collision? _____ mph

Did any part of your body strike anything in the vehicle? ☐ Yes ☐ No

As a result of the accident, were traffic citations issued to you? ☐ Yes ☐ No

Did you feel pain immediately after the accident? ☐ Yes ☐ No ☐ Later that day ☐ Next day ☐ other _____

Where did you feel pain immediately after the accident? _____

Were you aware of the approaching collision prior to impact? ☐ Yes ☐ No

Did you lose consciousness (black out) upon impact? ☐ Yes ☐ No, for how long? _____

Was the trunk of your body pointed straight forward at the time of impact? ☐ Yes ☐ No

if no, how was it turned? _____

Was your head pointed straightforward? ☐ Yes ☐ No

if no, what direction was it turned and how much? _____

Have you seen any other doctor for this injury? ☐ Yes ☐ No, if yes who? _____

Are you under any other doctor's care right now? ☐ Yes ☐ No, if yes who? _____

Have you ever had any complaints in the involved area prior to the accident? ☐ Yes ☐ No

if yes what were they? _____

Are your work activities restricted as a result of this accident? ☐ Yes ☐ No

if so, how? _____

Have you lost any days of work? ☐ Yes ☐ No If yes, from .through _____

Today's Date:____ /____ /____ **Signature** _____