A Healing Space

Auto/Personal 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
☐ Neck Stiffness	☐ Cold Sweat	☐ Loss of Balance
☐ Back Pain	☐ Fever	☐ Loss of Taste
☐ Tension	☐ Fatigue	☐ Loss of Smell
☐ Stomach Upset	☐ Numbness in Fingers	☐ Face Flushed
☐ Diarrhea	☐ Numbness in Toes	☐ Dizziness
☐ Constipation	☐ Hands Cold	☐ Fainting
☐ Pins and Needles in Arms	☐ Feet Cold	☐ Depression
☐ Pins and Needles in Legs	☐ Shortness of Breath	☐ Irritability
☐ Buzzing in Ears	☐ Chest Pain	☐ Nervousness
☐ Ringing in Ears	☐ 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 the Auto Insurance paying the medical bills? _____

Date of Injury _____ Have you reported this to your Insurance? ☐ Yes ☐ No

Do you have an open PIP claim? ☐ Yes ☐ No PIP Claim Number _____

PIP Medical Adjuster Name _____ Phone _____

Do you have an Attorney? ☐ Yes ☐ No

If yes, who? _____ Phone _____

Please Mark When/Where Appropriate

Describe the circumstances of the accident _____

_____

_____

Is your condition getting any worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

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

Were you the ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Bicyclist

Were you using a seatbelt? ☐ Yes ☐ No

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

Did your car strike others involved? ☐ Yes ☐ No

What speed was your vehicle going at the moment of the collision? _____ MPH

What speed was the other vehicle going at the time of the 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 lost consciousness (black out) upon impact? ☐ Yes ☐ No If yes, 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 straight forward? ☐ 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 yes, how so? _____

Have you lost any days of work? ☐ Yes ☐ No If yes, from what date to what date? _____

Signature _____ Date _____