

FOR PERSONAL INJURY

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last First Middle

Date of Accident: \_\_\_\_\_ Hour \_\_\_\_\_ AM \_\_\_\_\_ PM \_\_\_\_\_ Location: \_\_\_\_\_  
City

How did the accident happen? \_\_\_\_\_

If an auto accident, were you the Driver  Passenger  Front Seat  Back Seat  Pedestrian

If an auto collision, were you struck from Behind  Right Side  Left Side  Front  Auto was stopped

Did your car strike the other(s) involved? Yes  No ; or did the other car strike yours? Yes  No  Undetermined

As a result of the accident were traffic citations issued to you? Yes  No ; to the driver of the other car? Yes  No

To the driver of your car? Yes  No

What did you feel immediately after the accident? \_\_\_\_\_

When did you first notice symptoms from the accident? \_\_\_\_\_

Did you require post-accident hospitalization? Yes  No  Where? \_\_\_\_\_

List all doctors and type of treatment since accident: \_\_\_\_\_

CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

- Headache
- Neck Pain
- Neck Stiff
- Sleeping Problem
- Back Pain
- Nervousness
- Tension
- Irritability
- Chest Pain
- Dizziness
- Head feels Heavy
- Pins & Needles in Arms
- Pins & Needles in Legs
- Numbness in Fingers
- Numbness in Toes
- Shortness of Breath
- Fatigue
- Depression
- Vision Changes
- Loss of Memory
- Ringing in Ears
- Vomiting
- Buzzing in Ears
- Loss of Balance
- Fainting
- Loss of Smell
- Loss of Taste
- Diarrhea
- Cold Feet
- Cold Hands
- Stomach Upset
- Constipation
- Cold Sweats
- Fever

List injuries other than above: \_\_\_\_\_

Have you lost any days of work? \_\_\_\_\_ Dates: \_\_\_\_\_

Insurance companies involved:

My Company: \_\_\_\_\_ Address: \_\_\_\_\_

Company of person responsible for injuries: \_\_\_\_\_

Name of person responsible for injuries: \_\_\_\_\_

Have you been contacted by an insurance representative regarding this claim? Yes  No

Do you have an attorney that has advised you in this claim? Yes  No

If yes: Attorney Name \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_

SIGNED (patient, or parent if minor): \_\_\_\_\_