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 ☐ ↔Right side ☐ Left side ☐

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

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):_____