

**IF YOURS IS AN AUTOMOBILE ACCIDENT INJURY
PLEASE COMPLETE THE FOLLOWING FORM**

Date of Accident: _____ Hour: _____ AM PM Location: _____
 What type of Vehicle were you in? _____
 If Auto Accident, were you: Driver _____ Passenger _____ Pedestrian _____ | |
 Were you seated in the? Front _____ Back _____ Other _____ | |
 Was your vehicle? Stopped _____ Traveling _____ Facing: N, S, E, W ---- ----
 Did the other car strike yours? NO, Yes Front, Rear Left Side, Right Side ---- ----
 Did your car strike the other car? No, Yes Front, Rear Left Side, Right Side | |
 Did your car have any damage: No, Yes Where? _____ | |
 At the time of the collision were you wearing seatbelts? No, Yes
 At the time of the collision were you thrown about? No, Yes
 Did you strike any body parts? No, Yes What body parts? _____
 What part of the Auto did you hit against? _____
 Were there any Cuts, Bruises, Dislocation, Fractures? No, Yes Where? _____
 Did you notice immediate pain? No, Yes Where? _____
 Were you rendered Unconscious? No, Yes
 Did you walk from the car unaided? No, Yes
 Where did you go after the accident? _____
 How did you get there? _____
 If you were seen by another physician, were you examined? No, Yes
 What treatment did you receive? _____
 Did you stay in confinement? No, Yes Where? _____
 How did you feel the night of the accident? _____
 How did you feel the next day? _____ Note areas of pain. _____

Previous Doctors you have seen

Dr. _____ When _____ What treatment _____
 Dr. _____ When _____ What treatment _____
 Dr. _____ When _____ What treatment _____

Have you ever had similar symptoms before this accident? No, Yes Explain _____

AFTER YOUR ACCIDENT, describe your lifting ability:

1. How much weight can you now lift without experiencing pain, discomfort or restricted motion? ___ lbs
2. Did you experience this pain, discomfort or restriction before your accident? No, Yes
3. Have your present complaints interfered with any other activities? No, Yes
4. Are you now limited in your lifting ability or body movement that you were previously not?
 No, Yes Please describe _____
5. Have you missed any days of work? No, Yes First day missed _____ Thru _____
6. What are your job duties? _____

Insurance Companies Involved:

My auto insurance company: _____
 Insurance company of person responsible for injuries: _____

Have you been contacted by an adjuster or company representing this claims? No, Yes Who?
 Name _____ Address _____ Telephone _____

Do you have an attorney that has advised you in the case? No, Yes Who?
 Name _____ Address _____ Telephone _____