PERSONAL INJURY INTAKE

Date of Accident: ________________ Time of Day ___________________

Were you the… ( ) Driver ( ) Front Seat Passenger ( ) Back Seat Passenger ( ) Third Row Seat Passenger

# of people in your vehicle? _____ Other Vehicle? _____ Year/Make/Model your vehicle?_____________________ Other vehicle?_______________________

What direction were you headed? ( ) North ( ) East ( ) South ( ) West on (name of street) ____

What direction was the other vehicle headed? ( ) North ( ) East ( ) South ( ) West on (name of street) ____

Were you struck from: ( ) Behind ( ) Front ( ) Left rear side ( ) Right rear side ( ) Left front side ( ) Right front side

Did you lose consciousness? ( ) Yes ( ) No If yes, for how long? ____

Did the police respond? ( ) Yes ( ) No Did the EMS respond? ( ) Yes ( ) No Were you transported to the ER? ( ) Yes ( ) No

Have you retained an attorney? ( ) Yes ( ) No Name ____ Phone__________________________

Were there any witnesses? ( ) Yes ( ) No Name(s) ____

In your own words, please describe accident: ____

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Did you have any physical complaints BEFORE THE ACCIDENT? ( ) Yes ( ) No If yes, please describe in detail: ___________________________

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Please describe how you felt:

DURING the accident: ____

IMMEDIATELY AFTER the accident: ____

LATER THAT DAY: ____

THE NEXT DAY: ____

Do you have any congenital (from birth) factors which relate to this problem? ( ) Yes ( ) No If yes, please describe: _________________________

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Do you have any previous illnesses which relate to this case? ( ) Yes ( ) No If yes, please describe: ____

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Have you ever been involved in an accident before? ( ) Yes ( ) No If yes, please describe, including date(s) and type(s) of accidents, as well as injuries sustained. ____

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Where were you taken after the accident? ____

Have you ever been treated by another doctor since the accident? ( ) Yes ( ) No

If yes, please list doctor's name and address: ____

What type of treatment did you receive? ____

Since this injury occurred, are your symptoms: ( ) Improving ( ) Getting Worse ( ) Same

CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

Headache	Irritability	Numbness in Toes	Face Flushed	Feet Cold
Neck Pain	Chest Pain	Shortness of Breath	Buzzing in Ears	Hands Cold
Neck Stiff	Dizziness	Fatigue	Loss of Balance	Stomach Upset
Sleeping Problems	Head seems Too Heavy	Depression	Fainting	Constipation
Back Pain	Pins & Needles in Arms	Lights Bother Eyes	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	____________

Symptoms Other Than Above ____

Have you lost time from work as a result of this accident? ( ) Yes ( ) No

If yes, please complete this question.

Last Day Worked: ____

Type of Employment: ____

Are you being compensated for time lost from work? ( ) Yes ( ) No If yes, please state type of compensation you are receiving? ______________

Do you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No

If yes, please describe, in detail: ____

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Other pertinent information: ____

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Signature Date