

SUPPLEMENTAL HISTORY: AUTO ACCIDENT

Name _____ Today's Date _____ Time _____ am pm

Date of accident _____ Time of accident _____ am pm

Were you the: Driver Passenger in front seat Passenger in back seat

Were you wearing a seat belt? Yes No

How many vehicles were involved in the accident? One Two Three Four Other _____

How many people were in your vehicle? One Two Three Four Other _____

Make and model of your vehicle _____

Make and model of the other vehicle _____

What direction were you headed? North South East West

On what street? _____ In what city? _____ In what county? _____ In what state? _____

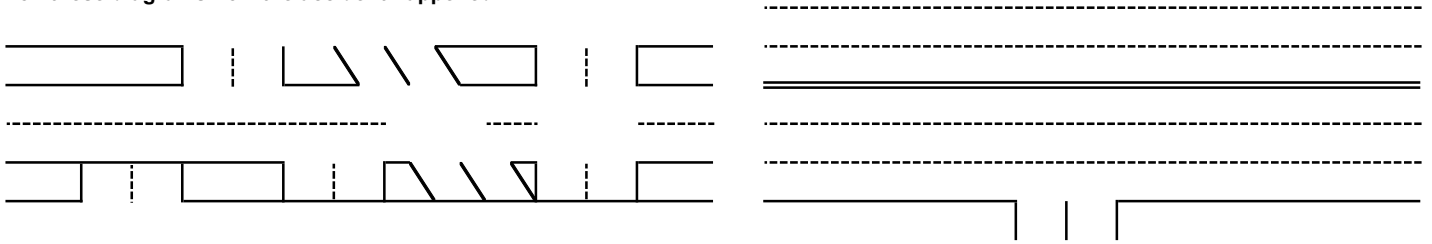
Type of accident: I was hit I hit someone else Rear-ended Broadside Head-on Other _____

Speed: Was your vehicle: Stopped Braking Moving _____ mph (Approximately) Forward Backward

Speed: Was the other vehicle: Stopped Braking Moving _____ mph (Approximately) Forward Backward

Visibility at the time of the accident: Good Poor Fair

Draw on these diagrams how the accident happened:



Describe the accident in your own words: _____

Approximate damage done to the car you were in (dollar amount) \$ _____ Damage estimate from body shop not completed yet

Were you aware the accident was going to happen before impact? Yes No

Did you brace yourself before impact? Yes No

Head position at the time of impact? Turned Right Left Straight ahead Looking back

Body position at the time of impact? Turned Right Left Straight ahead

Can you recall what parts of your head or body hit what parts of your car during the accident? _____

Could you move all your body parts after the accident? Yes No If no, explain: _____

As a result of the accident were you: Shaky / upset Disoriented / confused Rendered unconscious

Have you suffered from memory loss since the accident? Yes No If yes, describe: _____

Were you hospitalized? Yes No If yes, hospital _____

Have you been treated by a physician? Yes No If yes, name _____

What type of treatment? _____ How often? _____ Results _____

Are you still being treated? Yes No

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Describe how you felt:

During the accident _____

Immediately after the accident _____

Later that day _____

The next day _____

Please check your current symptoms:

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Jaw / TMJ pain (R / L) | <input type="checkbox"/> Arm tingling / numbness (R / L) | <input type="checkbox"/> Radiating pain to hip / leg (R / L) | <input type="checkbox"/> Muscle spasms / soreness |
| <input type="checkbox"/> Headache (R / L) | <input type="checkbox"/> Elbow pain (R / L) | <input type="checkbox"/> Hip / leg pain (R / L) | <input type="checkbox"/> Anxiety / depression |
| <input type="checkbox"/> Neck pain (R / L) | <input type="checkbox"/> Wrist pain (R / L) | <input type="checkbox"/> Leg tingling / numbness (R / L) | <input type="checkbox"/> Dizziness / fainting |
| <input type="checkbox"/> Mid back pain (R / L) | <input type="checkbox"/> Hand pain (R / L) | <input type="checkbox"/> Knee pain (R / L) | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Radiating pain to head (R / L) | <input type="checkbox"/> Hand tingling / numbness (R / L) | <input type="checkbox"/> Ankle pain (R / L) | <input type="checkbox"/> Ringing / buzzing in the ears |
| <input type="checkbox"/> Radiating pain to shoulder / arm (R / L) | <input type="checkbox"/> Low back pain (R / L) | <input type="checkbox"/> Foot pain (R / L) | <input type="checkbox"/> Visual disturbances |
| <input type="checkbox"/> Shoulder / arm pain (R / L) | <input type="checkbox"/> Sacroiliac pain (R / L) | <input type="checkbox"/> Foot tingling / numbness (R / L) | <input type="checkbox"/> Other _____ |

List any other present complaints and symptoms _____

Before the accident did you have any of your present complaints? Yes No

If yes, describe _____

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

If yes, list dates lost _____ Type of employment _____

Insurance companies involved:

Insurance company of party responsible for payment _____

Claim # _____ Phone _____ Adjustor _____

Your automobile insurance company _____

Agent _____ Phone _____ Do you have Med-Pay coverage? Yes No I'm not sure

Your group health insurance company _____

Policy # _____ Phone _____

Have you retained an attorney? Yes No

If yes, who? _____ Phone _____

Assignment Of Benefits

By signing this form you authorize your insurance company to make payments directly to this clinic; however, you are ultimately responsible for payment. If your insurance company sends checks to you, you are legally obligated to bring them to us.

Signature of patient or legal guardian

Date

Clinic Representative