Name _____
Date_____

PERSONAL INJURY – PATIENT DATA FORM

1. Date of Accident: _____
2. Time: _____(AM/PM)
3. Driver of vehicle: _____
4. Where were you seated? _____
5. Who owns the car? _____
6. Year/Model of car: _____
7. What was the approximate damage done to you vehicle? $_____
8. Visibility at the time of accident: poor/fair/good/other (please describe):
   _____
9. Road Conditions at the time of the accident: icy/rainy & wet/clear/other (please describe):
   _____
10. Where was your car struck? right/left/rear/front/side/other (please describe):
    _____
11. Type of accident:
    ( ) head-on collision ( ) broad-side collision
    ( ) rear-end collision ( ) front impact, rear-ended car in front
    ( ) non-collision (please describe):
    _____
12. Describe in your own words what happened to you on impact:
    _____
13. Did you see the accident coming? Yes/No
14. If yes, did you brace for the accident? Yes/No
15. Were seat belts worn? Yes/No
16. Were shoulder harnesses worn? Yes/No
17. Does your car have headrests? Yes/No
18. If yes, what was the position of those headrests compared to your head before the accident?
    ( ) top of headrest even with ***bottom*** of head.
    ( ) top of headrest even with ***top*** of head.
    ( ) top of headrest even with the ***middle of neck***.
19. Was the car braking? Yes/No
20. Was your car moving at the time of the accident? Yes/No
21. If yes, how fast would you estimate you were going? _____ (km/hour)
22. How fast was the other vehicle traveling? _____ (km/hour)
23. Head/Body position at the time of impact:
    ( ) head turned to the left/right ( ) body straight in the sitting position
    ( ) head looking back ( ) body rotated left/right
    ( ) head straight forward ( ) other: _____

24. At the time of the accident, recall what parts of your ***head*** or ***body*** hit what parts on the inside of your car:

_____

25. As a result of the accident were you:
    ( ) rendered unconscious ( ) dazed, circumstances vague
    ( ) other: _____
26. Could you move all parts of your body? Yes/No
27. If no, what parts and why?

_____

28. Were you able to get out of the car and walk unaided? Yes/No
29. If no, why not?

_____

30. What bleeding cuts did you get from the accident?_____
31. What bruises did you get from the accident?_____
32. Please describe how you felt: (Be specific)
    a) ***Immediately after the accident:***

_____

_____

_____

    b) ***Later that _____ Day _____ Night:***

_____

_____

_____

    c) ***The next _____ Day _____ Days:***
33. Check symptoms that are apparent ***since*** the accident:

( ) headache	( ) loss of smell	( ) numbness in fingers
( ) neck pain/stiffness	( ) loss of taste	( ) cold hands
( ) mid back pain	( ) loss of memory	( ) cold feet
( ) low back pain	( ) fatigue	( ) diarrhea
( ) eyes sensitive to light	( ) tension	( ) constipation
( ) pain behind eyes	( ) shortness of breath	( ) chest pain
( ) dizziness	( ) irritability	( ) nervousness
( ) fainting	( ) depression	( ) cold sweats
( ) ringing/buzzing ears	( ) sleeping problems	( ) anxious
( ) loss of balance	( ) numbness in toes	

    ( ) other _____
34. Occupation: _____ Employer: _____
35. Have you missed time from work? Yes/No
36. If yes, Full-time off work: dates _____ to _____
    Part-time off work: dates _____ to _____
37. Have you been unable to work since the accident? Yes/No
38. Did you seek medical help immediately/soon after the accident? Yes/No
39. If yes, how did you get there?
    ( ) someone else drove me ( ) ambulance
    ( ) drove own car ( ) police
    ( ) other _____

40. ***DOCTOR 1/HOSPTIAL/CLINIC SEEN*:** _____ date _____
41. Were you examined? Yes/No
42. Were X-rays taken? Yes/No
43. If yes, of what body parts?

_____

44. What treatment was given to you?
    ( ) bed rest ( ) brace ( ) physiotherapy
    ( ) adjustments ( ) medications ( ) other _____
45. What benefits did you receive from the treatment?

_____

_____

46. Date of last treatment: _____
47. ***DOCTOR 2/HOSPTIAL/CLINIC SEEN*:** _____ date _____
48. Were you examined? Yes/No
49. Were X-rays taken? Yes/No
50. If yes, what body parts? _____
51. What treatment was given to you?
    ( ) bed rest ( ) brace ( ) physiotherapy
    ( ) adjustments ( ) medications ( ) other _____
52. What benefits did you receive from the treatment?

_____

_____

53. Date of last treatment: _____
54. ***DOCTOR 3/HOSPTIAL/CLINIC SEEN*:** _____ date _____
55. Were you examined? Yes/No
56. Were X-rays taken? Yes/No
57. If yes, what body parts? _____
58. What treatment was given to you?
    ( ) bed rest ( ) brace ( ) physiotherapy
    ( ) adjustments ( ) medications ( ) other _____
59. What benefits did you receive from the treatment?

_____

_____

60. Date of last treatment: _____
61. Did you have any physical complaints ***just before the accident***? Yes/No
62. If yes, please explain in detail:

_____

_____

63. ***Prior*** to this accident, have you ***ever*** had symptoms similar to what you're experiencing now? Yes/No
64. If yes, please explain:

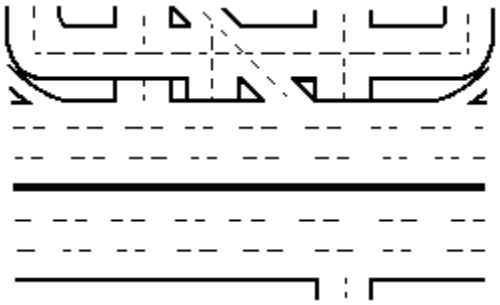
_____

_____

_____

(briefly include past falls, injuries, motor vehicle accidents, operations, etc.)

65. Do you notice any activities of your home daily routine that are different ***now*** than from ***before*** the accident? Yes/No
66. If yes, list them as:
67. Those that you are ***unable*** to do: _____
68. Those that are ***painful*** to do: _____
69. Those that are ***difficult*** to do: _____
70. Indicate on this diagram how the accident occurred:



80. Do you have an attorney on this case? Yes/No
    If yes, who?
    Name: _____
    Address: _____
    City _____ Postal Code_____

_____ _____
(PATIENT SIGNATURE) (DATE)

AUTOMOBILE ACCIDENT – INSURANCE DATA

1. Patient's Insurance Company Information:
Company Name: _____
Phone: _____
Address: _____City_____Postal Code_____
Policy #: _____
Adjuster's Name: _____
2. Insured's Insurance Information:
Insured's name if other than patient: _____
Phone: _____
Address: _____City_____Postal Code_____
Policy #: _____
Adjuster's Name: _____
3. Other Driver's Insurance Information:
Other Driver's Name (if another car was involved): _____
Phone: _____
Company Name: _____
Policy #: _____
Adjuster's Name: _____