COLLISION INFORMATION

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Name _____Today's Date_____

Where did the collision occur: Street: _____ City _____ State _____

Date the collision occurred: _____ AM or PM Was the road: ❑Dry ❑Wet ❑Snowy ❑Icy

Where you the ❑Driver ❑Front Middle Passenger ❑Front Right Passenger ❑Back Left ❑Back Middle ❑Back Right

Describe what happened:

_____

_____

_____

_____

_____

CRASH DETAILS

❑Yes ❑No If driving, were both hands on the wheel at impact?
❑I was not the driver.

❑Yes ❑No If passenger, did your hands brace yourself?
❑I was the driver.

❑Yes ❑No Did you have your seat belt and shoulder strap on?

❑Yes ❑No Was your seat up at the time of impact?

❑Yes ❑No Were you wearing a bulky coat or slipper pants?

❑Yes ❑No Did the seat belt engage?

❑Yes ❑No Did the airbag engage?

❑Yes ❑No Did you hit the dash, steering wheel or window?

❑Yes ❑No Did you know you were going to be hit?

❑Yes ❑No Did you brace yourself with hands or feet?

❑Yes ❑No If driving, was your foot on the brake at impact?
❑I was not the driver.

❑Yes ❑No Was your head turned at impact?

❑Yes ❑No Were you leaning forward at impact?

❑Yes ❑No Did your glasses fly off at impact?

❑Yes ❑No Was your body turned at the moment of impact?

❑Yes ❑No Did you get hit into another car, tree, railing etc.?

❑Yes ❑No Was there any damage or marks on your vehicle, the vehicle that hit you, or another object that was hit?

What part of the vehicle was hit? _____

1. What was the make and model of vehicle were you in? _____ The other vehicle? _____
2. What kind of seat were you in? ❑Bucket ❑Bench ❑Fabric ❑Leather/Vinyl
3. Did the car have headrests? ❑Yes ❑No On the back window if in a small truck? ❑Yes ❑No
4. Did you hit your head on the headrest? ❑Yes ❑No On the back window if in a small truck? ❑Yes ❑No
5. Where was the headrest position in regards to the center of your head: ❑Below ❑Level With ❑Above
6. Was anyone else in the car you were in at the time of the accident? ❑Yes ❑No If YES please list who and your relationship:

(Name) _____ - (Relationship) _____ (Name) _____ - (Relationship)

(Name) _____ - (Relationship) _____ (Name) _____ - (Relationship)

7. Is there anything else you want us to know? _____

_____

_____

_____

INJURY

1. Did your head hurt after the collision? ❑Yes ❑No
2. Did your TMJ/jaw hurt after the collision? ❑Yes ❑No
3. How soon after the collision did you notice any pain? _____
4. Have you lost any days of work due to your accident? ❑Yes ❑No Dates: _____

Check symptoms or problems that you have noticed since your accident:

❑Dizziness	❑Shortness of Breath	❑Sleeping Problems	❑Chest Pain	❑Light Bothers Eyes	❑Balance
❑Nightmares	❑ Painful Breathing	❑Fatigue	❑Head Feels Heavy	❑Ability to Read	❑Ability to Listen
❑Memory Loss	❑Nausea	❑Vision Problems	❑Pins/Needles in Arms	❑Ears Ring	❑Loss of Taste
❑Neck Pain	❑ Loss of Appetite	❑Irritability	❑ Pins/Needles in Legs	❑Ears Buzz	❑ Loss of Smell
❑Headaches	❑Increase of Appetite	❑Stomach Upset	❑Numbness in Fingers	❑Face Flushed	❑Feet Cold
❑Neck Stiffness	❑Back Pain	❑Constipation	❑Numbness in Toes	❑Loss of Balance	❑Hands Cold
❑ Concentration	❑Nervousness	❑Diarrhea	❑Depression	❑Fainting Spells	❑Cold Sweats
❑Fever	❑Symptoms Other than Above: _____				

_____

PROVIDERS SEEN

List <u>all</u> providers seen since the injury occurred:

1. Clinic/Doctor/Hospital Name: _____ City: _____
2. Clinic/Doctor/Hospital Name: _____ City: _____
3. Clinic/Doctor/Hospital Name: _____ City: _____
4. Clinic/Doctor/Hospital Name: _____ City: _____
5. Clinic/Doctor/Hospital Name: _____ City: _____

❑Yes ❑No Do you have pictures of your vehicle? Where is it being repaired? _____

❑Yes ❑No Do you have a copy of the police report?

INSURANCE INFORMATION

Have you received PIP (Personal Injury Protection) forms from your insurance company?
❑Yes ❑No – If no, call your insurance immediately to request forms.

Have you returned your PIP (Personal Injury Protection) forms back to your insurance company?
❑Yes Date Returned: _____
❑No – If no, complete and return immediately as you are responsible for payment on your account until your insurance receives these forms.

Name of Your Car Insurance: _____ Claim #: _____

Address: _____

_____

Adjustor's Name: _____

Adjustor's Phone #: (_____)_____-_____

Adjustor's Fax #: (_____)_____-_____

Name of the Other Driver's car Insurance if Applicable: _____

Name of Attorney if applicable: _____

Patient Signature: _____ Date: _____