FOR AUTO ACCIDENT IN JURIES ONLY **Name**___________________________ **Driver's License #**___________________

GENERAL ACCIDENT INFORMATION: Date of accident__________ Hour_____ AM PM

Describe how the accident specifically occurred____

____

Specific Location ____

Did you have physical complaints before the accident? □Y □ **N** **If yes, describe**___________________________________

What were your immediate symptoms after the accident? ______________________________________

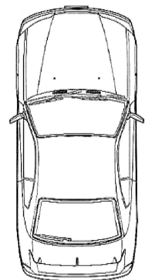
Did you require hospitalization? □Y □ N **Hospital?**____________________ **Transported by ambulance?** □Y □N

Attending physician: ______________ X-ray findings: _______________ **Medications Given:** __________

Have you lost any days of work? □ Y □ N **If yes, how many?** _____ **Income loss $** ____________

Treatment received since accident from M.D. Hospital, Chiropractor, Dentist, Physical Therapist, etc.:

Dr's Name	Type	Dates Seen	Phone#	Amount of Bill
________________________	___________	___________	___________	__________
________________________	___________	___________	___________	__________
________________________	___________	___________	___________	__________



VEHICLE SPECIFICS: Year, make, and model of the vehicle you were in ____

Circle the part(s) of your car that was damaged and place an "X" where you were seated in the image.

Others in the car with you: ____

Road conditions: □ Dry □ Wet □ Icy □ Gravel Road **Visibility Outside**: □ Good □ Moderate □ Poor

At impact, was your vehicle: □ Stopped □ Moving (speed: ___MPH) **Direction headed**: □ N□ S □ E □ W

Did the vehicle you occupy strike something during the collision? If so what? ___________________________________

If you struck another vehicle, was the vehicle: □ Stopped □ Moving **If moving, estimate speed**: ______MPH

What was the estimated cost of repair to the vehicle you were in? $_________ □ Unknown

Who was at fault for the accident? □ You □ Driver of car you were in □ Other driver □ Undetermined

Was your head facing straight ahead at impact? □ Y □ N **If not, how was it turned?** ______________________________

Were you wearing a seat belt? □ Y □ N **What type?** □ Lap □ Shoulder □ Both **Did an airbag inflate?** □ Y □ N

Did your body strike any part of your vehicle? □ Y □ N **Describe**____

Did you lose consciousness? □ Y □ N **How long?** _________ **Did you brace yourself for the collision?** □ Y □ N

Have you been in previous auto accidents? □ Y □ N **Describe:** Date: ________ Injuries:_____________________________

Have you completed and returned an "Application for Benefits" form to the insurance company? □ Y □ N

Your Vehicle's Auto/ Insurance Co._______________________________ Insured's Name____________________________

Billing address_______________________ ____________________________________ Phone (___)____________
Address City State Zip

Policy #__________________ Claim # _____________________ Adjuster's Name_________________________________

Auto Insurance company that insured the other vehicle Involved: ____

Billing address________________ ____ Phone (___)____________
Address City State Zip

Policy #__________________ Claim # _____________________ Adjuster's Name_________________________________

Have you retained an attorney for this case? □ Y □ N If yes: Name____

Address________________________ ____________________________________ Phone (___)____________
Address City State Zip

[Type text]

Symptoms After an Accident **Name**____

Fill in symptoms you now **have that you didn't have** ***before*** the accident.

Orthopedic & Musculoskeletal Symptoms

- □ "Clunk" Sound with Neck Movements
- □ Neck Pain
- □ Upper back Pain
- □ Low Back Pain
- □ Shoulder Pain □Left □ Right
- □ Upper Arm Pain □Left □ Right
- □ Elbow Pain □Left □ Right
- □ Forearm Pain □Left □ Right
- □ Wrist Pain □Left □ Right
- □ Hand Pain □Left □ Right
- □ Hip Pain □Left □ Right
- □ Upper Leg Pain □Left □ Right
- □ Knee Pain □Left □ Right
- □ Low Leg Pain □Left □ Right
- □ Ankle Pain □Left □ Right
- □ Foot Pain □Left □ Right
- □ Jaw Pain
- □ Clicking in Jaw
- □ Pain When Chewing
- □ Face Pain
- □ Chest Pain
- □ Stomach Pain
- □ Bruse/Contusion to _____________________
- □ Abrasion/Scrape to _____________________
- □ Other Symptom_________________________
- □ Other Symptom_________________________

Neurological Symptoms

- □ Numbness / Tingling Arm / Hand □L □ R
- □ Numbness / Tingling Leg / Foot □ L □ R
- □ I am taking over-the-counter pain meds

Symptoms Associated with Injuries

- □ Range of Motion Problems
- □ Muscle Spasms
- □ Sleep Disruption
- □ Radiating Pain
- □ Anxiety

Brain Neuropsych/MTBI Symptoms

- □ Wanting to be alone / Feelings of Isolation
- □ Sleepiness/ Dozing During the Day
- □ Nausea/Vomiting
- □ Difficulty Concentrating / Day Dreaming
- □ Mood Swings Nervousness Impatient
- □ Disoriented/Confused
- □ Difficulty Speaking
- □ Appetite Change
- □ Pupils Different Sizes
- □ Room Spins/ Woozy Feeling / Fainting
- □ Balance Problems
- □ Difficulty Walking
- □ Difficulty Focusing/ Easily Distracted
- □ Personality Change
- □ Reading / Writing Problems
- □ Difficulty Adding / Subtracting
- □ Difficulty Learning New Things / Understanding
- □ Difficulty Remembering Things Like Numbers
- □ Difficulty Making Decisions / Organizing
- □ Change in Sexual Function
- □ Reduced Confidence
- □ Helplessness
- □ Apathy (Don't Care)
- □ Change in Sense of Smell / Taste
- □ Flashbacks to Accident
- □ Hearing Problems / Ringing in your ears

Rivermead Post-Concussion Symptoms Questionnaire

Compared with before the accident, do you now (i.e., over the past 24-48 hrs.) suffer from (circle):

Scale

0=Not Experienced
1=Same as before accident
2=A mild problem now
3=A moderate problem now
4=A severe problem now

Symptom					
Headaches	0	1	2	3	4
Feelings of Dizziness	0	1	2	3	4
Nausea and/or Vomiting	0	1	2	3	4
Noise Sensitivity or upset by loud noise	0	1	2	3	4
Sleep Disturbance	0	1	2	3	4
Fatigue, Tiring more easily	0	1	2	3	4
Being Irritable, easily angered	0	1	2	3	4
Feeling Depressed or tearful	0	1	2	3	4
Feeling Frustrated or Impatient	0	1	2	3	4
Forgetful or a Poor memory	0	1	2	3	4
Taking Longer to think	0	1	2	3	4
Blurred Vision	0	1	2	3	4
Double Vision	0	1	2	3	4
Light Sensitivity or upset by bright light	0	1	2	3	4
Restlessness	0	1	2	3	4