AUTO COLLISION CASE HISTORY

1. NAME_____ HOME PHONE_____

   CELL PHONE_____ CELL PHONE CARRIER_____

2. HOME ADDRESS_____CITY_____

   STATE_____ZIP_____EMAIL_____

3. SOCIAL SECURITY #_____BIRTH DATE_____ AGE_____

4. MARITAL STATUS: ____SINGLE ____MARRIED ____DIVORCED ____SEPARATED ____WIDOW

5. EMPLOYER:_____ OCCUPATION_____

6. WHAT WAS THE DATE OF THE ACCIDENT?_____

7. WAS THIS A WORK RELATED ACCIDENT? ___YES ___NO GENDER _____MALE _____FEMALE

8. PERSON TO CONTACT IN CASE OF EMERGENCY? _____ PHONE_____
   (You have given us permission to contact this person at any time regarding your treatment)

9. DO YOU HAVE AN ATTORNEY? ___YES ___NO. IF YES, NAME OF ATTORNEY_____

10. DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING DISEASES? (PLACE AN "X" BESIDE THE DISEASE)
    ___HIV+ ___ARTIFICIAL JOINTS ___BURSITIS ___BLOOD CLOTS ___DIABETES ___CANCER
    ___LEUKEMIA ___COLON DISEASE ___MENTAL DISORDER ___HEPITITIS
    ___EMPHYSEMA ___ASTHMA ___GOUT ___GOITER ___ANEMIA ___SEIZURES ___EPILEPSY
    ___FAINTING SPELLS ___HIGH BLOOD PRESSURE ___HERNIA
    ___HISTORY OF STROKE OR HEART ATTACK ___LOW BLOOD SUGAR ___KIDNEY DISEASE
    ___MULTIPLE SCLEROSIS ___ARTHRITIS ___PARKINSON'S DISEASE ___PROSTATE DISEASE
    ___RUPTURED DISK ___VARICOSE VEINS ___RECENT FRACTURES ___OPEN WOUNDS
    ___RECENT SCARS ___RECENT BRUISES ___OTHER:_____ NONE _____

11. DO YOU HAVE ANY METAL IN YOUR BODY? (heart stents, braces, bullet fragments, pins/screws)
    ___YES ___NO IF YES, WHERE? _____

12. ARE YOU CLAUSTROPHOBIC? (Fear of small or closed in spaces) ___YES ___NO.

13. IS PREGNANCY CONFIRMED OR SUSPECTED AT THIS TIME? ___YES ___NO. DUE DATE_____

14. DO YOU HAVE HEALTH INSURANCE? ___YES ___NO. NAME OF HEALTH INSURANCE_____

15. WHO WAS THE DRIVER OF THE VEHICLE?_____

16. A.) Do you or your family own the vehicle that was involved in the accident? ___YES ___NO
    B.) If you were not the owner, did you have permission from the owner to drive? ___YES ___NO
    C.) Did the vehicle have liability insurance coverage? ___YES ___NO
    D.) Do you have UNINSURED MOTORIST (UM) coverage on the vehicle? ___YES ___NO

DATE_____ SIGNATURE (X)_____

AUTOMOBILE COLLISION QUESTIONNAIRE

1. NAME_____ DATE_____
2. WHAT WAS THE DATE OF THE ACCIDENT? _____
3. HOW MANY VEHICLES WERE INVOLVED IN THE ACCIDENT? _____
4. WHAT STREET OR INTERSECTION WERE YOU ON WHEN THE ACCIDENT HAPPENED?

   _____
5. WHAT CITY DID THE ACCIDENT OCCUR IN? _____
6. WHAT STATE DID THE ACCIDENT OCCUR IN? _____

   DESCRIBE THE ACCIDENT:_____

   _____
7. WHERE WERE YOU SITTING IN THE VEHICLE DURING THE ACCIDENT?

   _____DRIVER _____FRONT PASSENGER _____REAR LEFT PASSENGER _____REAR RIGHT PASSENGER

   _____PASSENGER ON A BUS _____OTHER Who was the driver?_____
8. DID YOU KNOW THE ACCIDENT WAS COMING? ____YES ____NO
9. WHAT TYPE OF VEHICLE HIT YOUR VEHICLE? ____CAR ____TRUCK ____SUV _____18-WHEELER
10. DID YOU LOSE CONSCIOUSNESS DURING THE ACCIDENT? ___YES ___NO
11. DID YOUR HEAD HIT ANYTHING INSIDE THE VEHICLE, INCLUDING THE HEADREST? ___YES ___NO
    IF YES, WHAT OBJECT DID YOUR HEAD HIT? _____
12. DID YOUR FACE HIT ANYTHING INSIDE THE VEHICLE? ___YES ___NO
    IF YES, WHAT OBJECT DID YOUR FACE HIT? _____
13. DID YOUR SHOULDER(S) HIT ANYTHING INSIDE THE VEHICLE? ___YES ___NO
    IF YES, WHAT OBJECT(S) DID YOUR SHOULDER(S) HIT? _____
14. DID YOUR CHEST HIT ANYTHING INSIDE THE VEHICLE? ___YES ___NO
    IF YES, WHAT OBJECT DID YOUR CHEST HIT? _____
15. DID YOUR HIP(s) HIT ANYTHING INSIDE THE VEHICLE? ___YES ___NO
    IF YES, WHAT OBJECT DID YOUR HIP(S) HIT? _____
16. DID YOUR KNEE(S) HIT ANYTHING INSIDE THE VEHICLE? ___YES ___NO
    IF YES, WHAT OBJECT DID YOUR KNEE(S) HIT? _____
17. DID YOUR FEET HIT ANYTHING INSIDE THE VEHICLE? ___YES ___NO
    IF YES, WHAT OBJECT DID YOUR FEET HIT? _____
18. WERE YOU WEARING A SEATBELT DURING THE ACCIDENT? ___YES ___NO
19. DID YOU GO TO THE HOSPITAL? ___ IF YES, DATE_____
    ___ IF NO, SKIP DOWN TO THE QUESTION #26.
20. HOW DID YOU GET TO THE HOSPITAL? ___DROVE YOURSELF ___PRIVATE TRANSPORTATION ___ AMBULANCE ___OTHER
21. WHAT WAS THE NAME OF THE HOSPITAL? _____

22. WERE YOU HOSPITALIZED OVERNIGHT? ___YES ___NO

23. WHERE YOU PRESCRIBED ANY MEDICATION? ___YES ___NO

24. DID YOU RECEIVE ANY STITCHES FOR ANY CUTS AT THE HOSPITAL? ___YES ___NO

25. WERE X-RAYS TAKEN AT THE HOSPITAL? ___YES ___NO
IF YES, WHICH AREA(S) WAS TAKEN? _____

26. WAS A MRI OR CT SCAN TAKEN AT THE HOSPITAL? ___YES ___NO
IF YES, WHICH AREA(S) WAS TAKEN? _____

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27. AS A RESULT OF YOUR RECENT ACCIDENT, PLACE AN (X) BY THE AREAS OF YOUR BODY THAT WERE INJURIED?

___HEADACHES	___SHOULDER JOINT	___HAND	___LEGS
___JAW	___ARM	___MID BACK	___KNEE
___NECK	___ELBOW	___LOW BACK	___ANKLE
___UPPER BACK	___WRIST	___HIP/BUTTOCKS	___FOOT
___HIT HEAD	___OTHER, DESCRIBE:_____		

28. WHAT IS YOUR HEIGHT? _____ WHAT IS YOUR CURRENT WEIGHT? _____

29. SINCE THE ACCIDENT, HAVE YOU EXPERIENCED ANY OF THE FOLLOWING?

___RINGING/BUZZING IN EARS ___POPPING JAW ___DID YOU HIT YOUR HEAD

___ANXIETY ___STRESS ___INSOMNIA ___LOSS OF APPETITE

___PAIN IN OR AROUND THE EYE ___SHORTNESS OF BREATH ___SORE THROAT

___CHEST PAIN ON BREATHING ___LOSS OF MEMORY ___DIZZINESS ___FATIGUE ___FAINTING

30. WHAT IS YOUR DATE OF BIRTH? _____

31. WHAT IS YOUR OCCUPATION? _____

32. ARE YOU TAKING MEDICATION FOR ANY HEALTH PROBLEMS NOT RELATED TO THIS ACCIDENT?
___YES ___NO IF YES, DESCRIBE_____

33. HAVE YOU HAD ANY SURGICAL PROCEDURES? ___YES ___NO
IF YES, WHEN AND DESCRIBE _____

33. IS THERE ANYTHING THAT WE NEED TO KNOW? ___YES ___NO
IF YES, PLEASE DESCRIBE_____

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34. HAVE YOU HAD ANY OTHER SERIOUS FALLS, HEAD INJURIES, BROKEN BONES OR ANOTHER AUTO ACCIDENT IN THE LAST 5 YEARS? ___YES ___NO
IF YES, WHEN AND DESCRIBE _____

35. HAVE YOU MISSED ANY DAYS OF WORK SINCE THE ACCIDENT? ___ YES ___NO
IF YES, HOW MANY DAYS HAVE YOU MISSED? _____

36. BEFORE THIS INJURY, WERE YOU CAPABLE OF WORKING ON AN EQUAL BASIS WITH OTHERS YOUR OWN AGE?
___ YES ___NO. IF NO, STATE YOUR DISABILITY _____

SIGNATURE (X)_____ DATE:_____