

PERSONAL INJURY PATIENT INFORMATION

Name _____ Today's date ____ / ____ / ____
 First Middle Last

SSN# ____ -- ____ -- DOB: ____ / ____ / ____ Sex: M F PH# ____ -- ____ --

Address _____
 Street Apt# City State Zip code

Referred by _____ Drivers License # _____

Date of Accident ____ -- ____ -- State of Wisconsin? Other State?: _____

Were you the Driver Passenger; if passenger: Front Seat Back Seat

Was the automobile insurance notified of this claim? YES NO

Do you have medical pay coverage available? YES NO Amount \$ _____

Were the police notified? YES NO

Were you examined after the accident? YES NO Where? _____

Have you missed work as the result of the accident? YES NO If yes, last date worked?: ____ / ____ / ____

Briefly describe your auto accident:

YOUR Automobile Insurance information: (If you were the passenger, driver's insurance information)

CLAIM # _____ Contact person: _____ Ext: _____

Company Name _____

Address _____ PH# ____ -- ____ --
 Street City State Zip Code

Your Health Insurance Information:

Insurance Co: _____ PH# ____ -- ____ --

Insured's Name _____
 First Middle Last

ID/Subscriber # of Insured _____ Group# _____

Insured DOB: ____ / ____ / ____ Insured's Employer _____
 Month Day Year

Attorney Information:

Have you retained an Attorney YES NO

If yes, name of attorney _____

Address _____ PH# ____ -- ____ --
 Street City State Zip Code

NAME _____ TODAY'S DATE ____/____/____
FIRST MIDDLE LAST

ACCIDENT DATE ____/____/____ TIME OF ACCIDENT ____:____ Am Pm

PATIENT: Driver Passenger; Moving Stopped ESTIMATED SPEED ____ MPH

ROAD CONDITIONS: Dry Damp Wet Rain Ice Snow

HEAD REST: None Integral Adjusted in Position

SEAT BELT: Wearing Not Wearing SHOULDER HARNESS: Wearing Not Wearing

HEAD POSITON: Facing Forward Facing left Facing right HANDS: One on Wheel Both on Wheel

AWARE OF IMPENDING COLLISION: Yes No

FELT BODY GO: Forward Backward Sideways Other: _____

SECOND COLLISION IN VEHICLE: Yes No If yes, explain _____

SECOND COLLISION OUTSIDE VEHICLE: Yes No If yes, explain _____

OTHER(S) IN THE VEHICLE: Driver Passengers Names: _____

WEARING GLASSES: Yes No GLASSES STILL ON AFTER COLLISION: Yes No

LOSS OF CONSCIOUSNESS: Yes No

INITIAL SIGNS AND SYMPTOMS: None Headache Dizziness Disoriented Shock

Neck Pain/stiffness Upper back pain/stiffness Middle back pain/stiffness Lower back pain/stiffness

Numbness/Tingling in: Arms Legs Other: _____

ONSET OF SIGNS AND SYMPTOMS: Date: ____/____/____ S M T W TH F S

HOURS AFTER ACCIDENT: _____

AFTER ACCIDENT I/WE WENT: Home Hospital; ASAP Later; VIA Ambulance Car

HOSPITAL PROCEDURES: X-rays Laboratory Tests Neck/Back Brace

Prescription: _____ Diagnosis _____

Instructions _____

WENT TO DOCTOR'S OFFICE: Dr Name: _____ Date: ____/____/____

Time: ____:____ Am Pm

POLICE INVOLVED: Yes No REPORT FILED?: Yes No

BRAKES: On Off TRANSMISSION: Manual Automatic

TYPE OF CAR: Year ____ Make ____ Model ____

OTHER CAR(S) INVOLVED: Year ____ Make ____ Model ____

LOCATION OF IMPACT: Front Back Right Side Left Side

ESTIMATED PROPERTY DAMAGE: \$ ____, ____, ____ Vehicle Drivable Vehicle Not Drivable

PRIOR MEDICAL CARE & DOCTOR: _____ Xrays Date ____/____/____

PRIOR CHIROPRACTIC CARE & DOCTOR: _____ Xrays Date ____/____/____

PREVIOUS MOTOR VEHICLE INJURIES: _____ Date ____/____/____

PREVIOUS WORKERS COMPENSATION INJURIES: _____ Date ____/____/____

PREVIOUS SPORTS INJURIES: _____ Date ____/____/____

PLEASE DRAW THE ACCIDENT SCENE:

