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:

____

____

____

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

CLAIM #_________________ Contact person:__________________________________Ext: _________

Company Name____

Address____ PH#_______--________--___________
Street City State Zip Code

<u>Your Health Insurance Information:</u>

Insurance Co:____________________________________ PH#________--_________--___________

Insured's Name____
First Middle Last

ID/Subscriber # of Insured______________________ Group# ___________________________________

Insured DOB: __________/_______/___________ Insured's Employer_______________________________
Month Day Year

<u>Attorney Information:</u>

Have you retained an <u>Attorney</u> ☐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/Tingiling 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: