COMPREHENSIVE CONSULTATION – P.I.

Patient's Name: _____ Date: _____ Acct #: _____

PATIENT HISTORY INFORMATION

A. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT/INJURY:

_____ Headache	_____ Irritability	_____ Numbness in toes	_____ Face flushed
_____ Neck pain	_____ Chest pain	_____ Shortness of breath	_____ Buzzing in ears
_____ Neck stiff	_____ Dizziness	_____ Fatigue	_____ Loss of balance
_____ Sleeping problems	_____ Head seems too heavy	_____ Depression	_____ Fainting
_____ Back pain	_____ Pins & needles in arms	_____ Lights bother eyes	_____ Loss of smell
_____ Nervousness	_____ Pins & needles in legs	_____ Loss of memory	_____ Loss of taste
_____ Tension	_____ Numbness in fingers	_____ Ears ring	_____ Diarrhea
_____ Feet cold	_____ Hands cold	_____ Stomach upset	_____ Constipation
_____ Cold sweats	_____ Fever		

Others: _____

_____

_____

_____

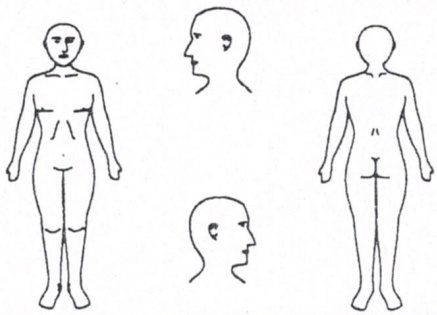
_____

_____

_____

_____

Please mark your areas of pain on the figures below.



B. ACCIDENT INFORMATION

1. **When** did the accident happen? _____ (Date) _____ (Time)
2. **Where** did the accident happen? _____ (City/Street)
3. Which were you? (Check only **one** box) ☐ Driver ☐ Passenger ☐ Pedestrian
4. Where were you **seated**? ☐ Left Front ☐ Right Front ☐ Left Rear ☐ Right Rear
5. What kind of vehicle were you in? _____ (type of vehicle)
6. Was your vehicle **moving** or **stopped** at the time of impact? ☐ Moving ☐ Stopped
7. Were you wearing a **seatbelt** at the time of the accident? ☐ Yes ☐ No
8. Did the driver of your vehicle have his/her foot on the **brakes** at the time of impact? ☐ Yes ☐ No ☐ Not Sure
9. **Was your vehicle struck by another vehicle?** ☐ Yes ☐ No
10. If yes, on which side was it struck? ☐ Front ☐ Back ☐ Left Side ☐ Right Side
11. How fast was the other vehicle moving? _____ (approximate miles per hour)
12. How fast was your vehicle moving? _____ (approximate miles per hour)
13. What is your estimate of the damage done to your vehicle? $ _____
14. Did your vehicle strike any other vehicle(s)? ☐ Yes ☐ No
15. If yes, which side? ☐ Front ☐ Back ☐ Left Side ☐ Right Side
16. Did any part of your body hit the inside of the vehicle you were in? ☐ Yes ☐ No
17. If yes, what body part? _____
18. What part of the vehicle did your body hit? _____
19. Were you aware of the possibility of a collision prior to impact? ☐ Yes ☐ No
20. What direction were you facing at the time of impact? ☐ Right ☐ Left ☐ Straight ahead