Automobile Accident Questionnaire

Please answer all questions completely

Dear Patient:

This information is considered confidential. Your answers will help us determine if physical therapy can help you. If we do notsincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

Name_____ Sex_____ Marital status_____ Date of Birth _____

Home Phone_____ Cell Phone_____ Email _____

Address_____ City_____ State_____ Zip_____

Occupation _____

Social Sec.#_____ Business phone _____ Company Name _____ Location _____

Spouse's First Name_____ Spouse Soc. Sec.#_____ Spouse's Employer_____ Location _____

Please explain in detail how your auto accident happened: _____

Time and date of present injury? _____

Where did you feel pain immediately after the accident? _____

List the extent of injuries as you know them: _____

Did you require post accident hospitalization? ❑ Yes ❑ No

Check symptoms you have noticed since the accident:

❑ Headache	❑ Dizziness	❑ Depression	❑ Fatigue
❑ Stomach upset	❑ Light bothers eyes	❑ Buzzing in ears	❑ Diarrhea
❑ Neck Pain	❑ Head seems too heavy	❑ Loss of memory	❑ Feet cold
❑ Neck Stiff	❑ Pins and needles in arms	❑ Ears ring	❑ Hands cold
❑ Fainting	❑ Sleeping problems	❑ Loss of Balance	❑ Back pain
❑ Face flushed	❑ Pins and needles in legs	❑ Constipation	❑ Tension
❑ Nervousness	❑ Numbness in Fingers	❑ Loss of Smell	❑ Fever
❑ Irritability	❑ Numbness in toes	❑ Loss of taste	❑ Chest pain
❑ Cold Sweats	❑ Shortness of breath	❑	❑

Symptoms other than above: _____

Where were you taken after the accident? _____

Hospitalized? ❑ Yes ❑ No If yes, admitted?_____ How long? _____

Name of Hospital _____

Name of Doctors _____

What treatment was given? _____

Was any other doctor consulted after your accident? ❑ Yes ❑ No

If so, what was the doctor's name? _____

What was the diagnosis? _____

What treatment was given? _____

How often did you see the doctor? _____

How long did you see the doctor? _____

Have your ever had any complaints in the involved area before? ❑ Yes ❑ No

Drivers of other vehicle (if any)

Name of driver of vehicle in which you were injured _____

Insurance Company _____ Policy number _____

Name of your insurance adjustor _____

Have you retained an attorney? ❑ Yes ❑ No

If so, attorney's name and address _____

You were heading ..... ❑ North ❑ East ❑ South ❑ West

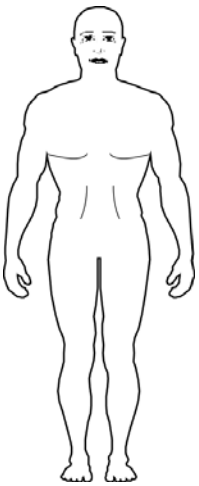
Other vehicle was heading ..... ❑ North ❑ East ❑ South ❑ West

Were police notified? ..... ❑ Yes ❑ No

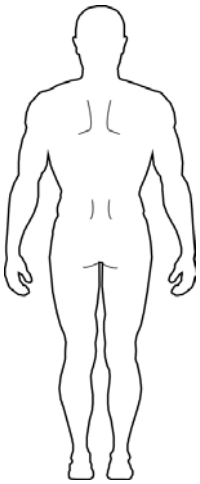
Were you knocked unconscious? ❑ Yes ❑ No

You were struck from ..... ❑ Behind ❑ Front ❑ Left side ❑ Right side

You were ..... ❑ Driver ❑ Passenger ❑ Front seat ❑ Back seat ❑ Using seat belts



MARK PAIN AREA



+++ Burning **000 Stabbing**
--- Sharp **III Consistent**

Additional details can be provided below

_____

_____

_____

_____

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this physical therapy office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this physical therapy office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or termi-nate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: _____ Date: _____

Guardian or Spouse's Signature: _____ Date: _____

Patient accepted? ❑ Yes ❑ No

Doctors Signature: _____ Date: _____