— AUTO ACCIDENT INFORMATION FORM —

We understand that your auto accident may have caused, among many other symptoms, problems with memory, concentration, and/or ability to accurately communicate. Thus, please complete the following questionnaire as completely and as accurately as your current condition allows. If choices are presented, use a check " ✓" to indicate the most appropriate response. If a question does not apply, write "N/A" (not applicable) next to it. If you are unsure, write a "?" next to it. Please PRINT all responses. Thank you.

Name: _____ Today's Date: _____

Age: _____ Date of Birth: _____ Sex: _____ Date of Injury: _____

At the time of the injury, were you the driver of the vehicle? ( )Yes ( )No

If not, where were you sitting at the time of the impact? ( )Front seat ( )Back Seat ( )Left ( ) Right ( )Center

Was this vehicle registered to you? ( )Yes ( )No If not, who was it registered to? _____

Was anyone else in the vehicle with you? ( )Yes ( )No If yes, please identify the person or persons below:

	Name	Relationship	Age	Injured?
1.				( )Yes ( )No
2.				( )Yes ( )No
3.				( )Yes ( )No
4.				( )Yes ( )No
5.				( )Yes ( )No

Were you on company business at the time? ( )Yes ( )No If yes, was it reported to employer? ( )Yes ( )No.

Location of the accident: _____

What were the road and weather conditions like? _____

Please describe, in detail, how the accident happened: _____

_____

_____

_____

_____

Please diagram the accident below:

Total number of vehicles involved in the impact: ( )1 ( )2 ( )3 ( )4

The impact to your vehicle occurred from the: ( )Front ( )Rear ( )Left side ( )Right side

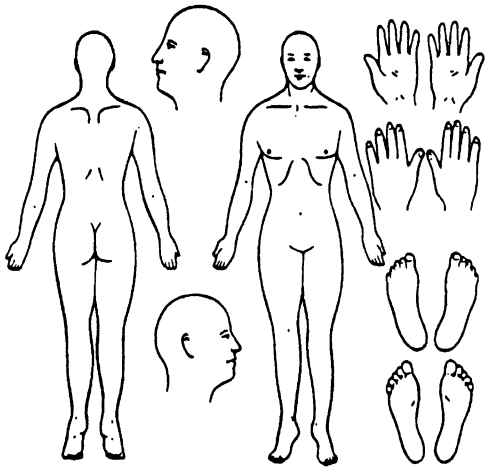
Total number of impacts to your vehicle: ( )1 ( )2 ( )3 ( )4

Were you wearing a: ( )Lap belt ( )Lap and shoulder belt

Was there a headrest? ( )Yes ( )No

Estimated speed of YOUR vehicle at the time of impact: _____mph ( )Stopped
Estimated speed of the OTHER vehicle at the time of impact: _____ mph ( )Stopped
Did you anticipate the impact? ( )Yes ( )No
How was your head positioned at the moment of the impact? _____
How was your torso positioned at the moment of the impact? _____
As best you can recall, did you strike anything inside the auto? ( )Yes ( )No
If yes, please indicate the probable item struck on the list below and draw a line to the region of the body struck.

( )Dashboard
( )Windshield
( )Side window
( )Steering wheel
( )Shifter
( )Headrest
( )Inner door panel
( )Ceiling
( )Armrest
( ) _____
( ) _____
( ) _____



Did any windows break in your vehicle? ( )Yes ( )No If yes, please identify: _____
Was there any "flying" glass from the impact? ( )Yes ( )No If yes, please identify: _____
Did you receive any? Cuts: ( )Yes ( )No Bruises: ( )Yes ( )No Abrasions: ( )Yes ( )No
If yes, to any of these, please describe: _____

_____

At the time of the accident, did you lose: consciousness:( )Yes No( ) bowel/bladder control: ( )Yes ( )No
Did you have any other unusual experiences? ( )Yes ( )No If yes, please identify: _____

_____

Please describe any damage done to the vehicle you were in: _____

_____

_____

_____

Make and model of the vehicle you were in: _____ Year: _____
Please describe any damage done to the other vehicle: _____

_____

_____

Make and model of other vehicle: _____ Year: _____

Were you able to get yourself out of the vehicle? ( )Yes ( )No If not, who helped you? _____
If assisted, describe how you were removed from the vehicle: _____

_____

Did you receive any first aid at the scene? ( )Yes ( )No If yes, by whom? _____
What specifically was done for you? _____
Who was called or came to the accident scene? ( )Highway Patrol, ( )Local police, ( )Sheriff, ( )Paramedics,
( )Ambulance, ( )Other _____
Was a report made? ( )Yes ( )No If yes, do you have a copy? ( )Yes ( )No ( )Not yet, but I will provide it.

Did you go to the emergency room? ( )Yes ( )No Urgent care? ( )Yes ( )No Doctor's office? ( )Yes ( )No
If you answered "yes" to any of the above three questions, please identify where you went and who attended you there:

_____

_____

What was done for you there: Examination: ( )Yes ( )No X-rays: ( )Yes ( )No
Pain medication: ( )Yes ( )No Muscle relaxants: ( )Yes ( )No
Antiinflammatories: ( )Yes ( )No Supports/Braces: ( )Yes ( )No

What diagnosis were you given? _____
Were you told to do anything by the doctor in attendance? ( )Yes ( )No If yes, please identify: _____

_____

Were you hospitalized at any time as a result of the injuries you sustained from the accident? ( )Yes ( )No If yes, please identify the name and location of the hospital, enter date, discharge date, and the name of the treating doctor: _____

_____

_____

What was done for you at the hospital? _____

_____

Please describe how you felt:

Immediately after the accident: _____

_____

Later that same day: _____

_____

The next day: _____

_____

Have you seen any other healthcare professional since the first day of the accident? ( )Yes ( )No If yes, please complete the form below. Begin with the person you saw first and proceed to the most recent.

Name	Title	Date(s) Seen	What Was Done For You?

Have you had any injury or significant illness *since* the auto injury? ( )Yes ( )No If yes, please describe: _____

_____

Have you had any signficant injury or illness, of any type, *prior* to the auto injury? ( )Yes ( )No If yes, what was the nature of the problem and when did it occur? If professional care was rendered, how long were you treated, by whom, and what was done? _____

_____

_____

_____

Prior to this auto accident, have you ever been hospitalized for any reason? ( )Yes ( )No If yes, what was the nature of the complaint or illness, when and where were you hospitalized, for how long, and what treatment was rendered to you?

_____

_____

Have you had any surgeries at any point in your life? ( )Yes ( )No If yes, when, what for, and by whom?_____

Are you aware of any congenital abnormalities you may have? ( )Yes ( )No If yes, please describe: _____

Have you ever served in the armed forces? ( )Yes ( )No If yes, what were the dates of service and what type of discharge did you receive?_____

Are you currently under any other doctor's care? ( )Yes ( )No If yes, who is the doctor and what is the doctor treating you for? _____

What medication, prescribed or not, are you currently taking to treat your auto accident injuries?_____

What medication, prescribed or not, are you currently taking to treat any condition unrelated to your auto accident injuries?_____

Do you currently use tobacco products? ( )Yes ( )No If yes, how much do you smoke per day?_____

Do you currently drink alcohol? ( )Yes ( )No If yes, how much and how often?_____

Did you have any recreational or hobby activities before the auto accident? ( )Yes ( )No If yes, what were they? _____

Before the auto accident, how would you rate your overall health? _____

Are you currently employed? ( )Yes ( )No If yes, what is your job title?_____

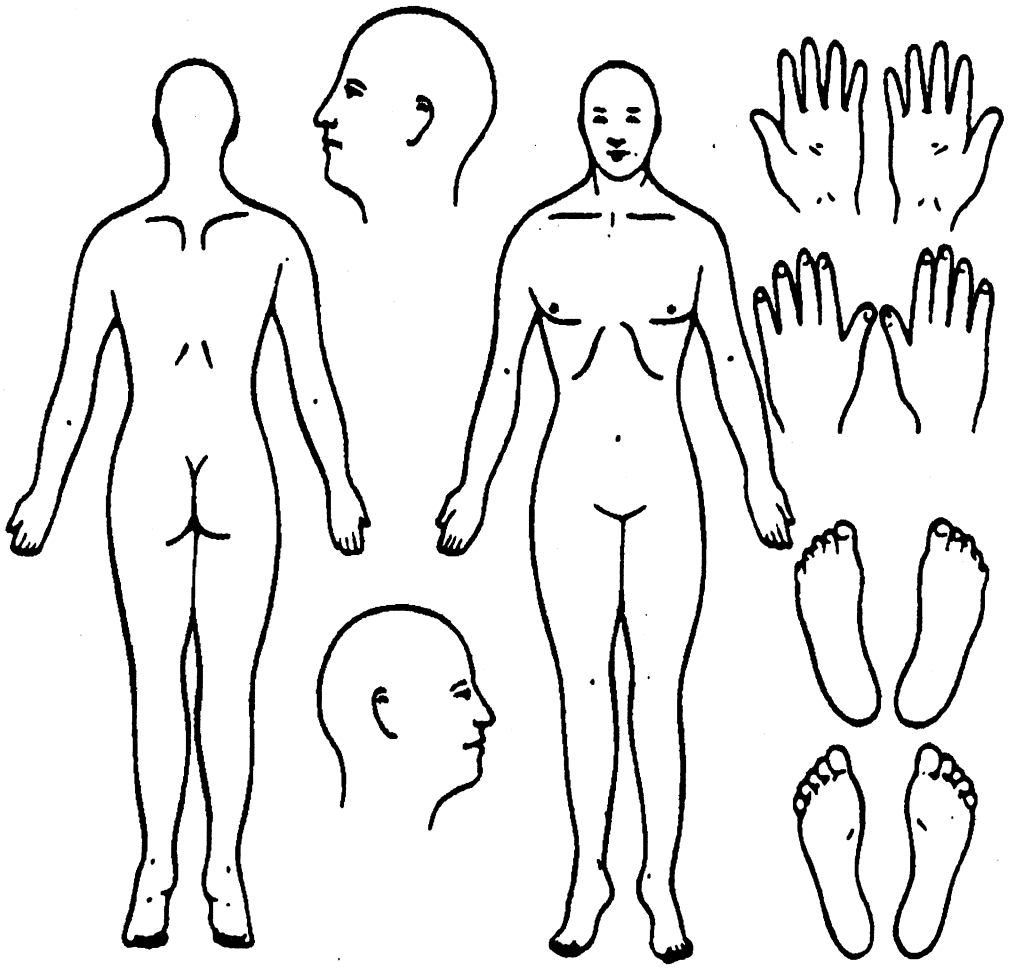
What are your job duties? _____

Have you missed any work and/or job opportunities as a result of the auto accident? ( )Yes ( )No If yes, please detail:

Please provide any additional information we should know about your case: _____

Current Medical Complaints

In the space below, please describe any medical complaints you are currently experiencing that you believe are related to the motor vehicle accident. Use the diagram to better identify the location and nature of your symptoms. Please indicate all areas of pain, stiffness, numbness, tingling, weakness, popping, and/or clicking.



Please sign and date this form: _____ _____

signature *date*