**Auto Injury Management**

@ Complete Care Health Services

3600 S Wadsworth Blvd Lakewood, CO 80235

Office: (303) 985-0646 Fax: (303) 985-3834

www.abetterbackclinic.com

**Auto Collision / Personal Injury Intake Form**

*(****Fill-in, Circle****, or Mark a* ***✓*** *on each that applies,* ***N/A*** *if does not applicable,* ***Blank*** *if don’t know)*

**Today’s Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Your Full Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Gender**: [ ] M [ ] F **Marital Status**: [ ]  Single [ ]  Married [ ]  Widowed [ ]  Separated [ ]  Divorced

**Birth Date**: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_

  **Height** \_\_\_\_\_\_\_\_\_\_ **Weight** \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Handed:** RT: \_\_\_ LT: \_\_\_\_

**Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State**: \_\_\_\_\_\_\_\_\_\_\_ **Zip**: \_\_\_\_\_\_\_\_\_\_\_

**Social Security No**.: \_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_ **Driver’s License No**.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home Phone:** (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cellular Phone**: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**E-Mail:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Work Phone:** (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Occupation:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employer**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employer Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Your Auto’s Insurance Information:**

**Insured’s Name (name the policy in under)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Last) (First)

**Relationship to patient (if policy is not under your name)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Company Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Auto Agents’ Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Agent’s phone Number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have Med-Pay coverage?** [ ] Yes [ ] No **Amount of Coverage**? : \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have under-insured / un-insured coverage?**  [ ] Yes [ ] No

**Have you been issued a Claim# for this accident?** [ ] Yes [ ] No

**Claim#:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Were you at fault for this accident?** [ ]  Yes [ ]  No

**Other Party‘s Auto Insurance Information ( If Applicable)**

Other party’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company name of other person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_

Claim Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you retained an attorney?**  [ ]  Yes [ ]  No

Your Attorney’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Attorney’s Phone#: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Attorney’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_

**Collision Information:**

**Date of Collision:** \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ **Time of Collision**: \_\_\_\_\_\_\_\_\_\_\_\_ a.m. / p.m.

**The Weather Conditions** were they: [ ]  Sunny [ ]  Raining [ ]  Snowing [ ]  Foggy

**The Road was**: [ ]  Dry [ ]  Wet [ ]  Icy

**Light of Day:** [ ]  Dawn [ ]  Day [ ] Dusk [ ]  Night

**Your Vehicle**: Year \_\_\_\_\_\_\_\_\_\_\_\_\_ Make \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Model\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Collision Type**: [ ] Rear ended [ ] Head-on [ ] Broad-sided [ ]  Side swiped

**Damage to Your Vehicle**: $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 [ ]  Drivable OR [ ]  Towed away

**Have you had your car repaired yet?** [ ]  Yes [ ]  No

(if applicable)

**Other Vehicle**: Year \_\_\_\_\_\_\_\_\_\_\_\_\_ Make \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Model\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other Vehicle Damage**: [ ]  Mild [ ]  Moderate [ ]  Severe

[ ]  Drivable OR [ ]  Towed away

**Unusual circumstances**: (please note)

(i.e.: was anyone drunk, under the influence, emotionally unstable, speeding, out of control etc.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Did you take Pictures?** : [ ]  Yes [ ]  No

(If so, of what) [ ]  My car [ ]  Other car(s ) [ ]  Accident scene [ ]  Injured body part(s)

**Collision Specifics**:

**Were you** the: [ ]  Driver [ ]  Passenger

If passenger, where **were you** sitting: [ ]  Front Seat OR [ ]  Back Seat

 [ ]  Right Side OR [ ]  Left Side

**Were you** wearing your seatbelt: [ ]  Yes [ ]  No

**Did the airbag deploy**: [ ]  Yes [ ] No

**Impending Collision, were you**: [ ]  Aware OR [ ]  Unaware

 [ ]  Braced OR [ ]  Not brace

**Right hand:** [ ]  Steering wheel [ ]  Center console [ ]  In Lap [ ]  Door ledge [ ]  Other: \_\_\_\_\_\_\_\_\_\_\_

**Left hand:** [ ]  Steering wheel [ ]  Center console [ ]  In Lap [ ]  Door ledge [ ]  Other: \_\_\_\_\_\_\_\_\_\_\_

**Right foot:** [ ]  Gas [ ]  Brake [ ]  Floor board [ ]  Fire wall [ ]  Other : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Left Foot:** [ ]  Gas [ ]  Brake [ ]  Floor board [ ]  Fire wall [ ]  Other : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Head position:** [ ]  Straight ahead [ ]  turned left [ ]  turned right [ ]  bent down [ ]  bent back

**Torso position:** [ ]  Straight ahead [ ]  turned left [ ]  turned right [ ]  bent down [ ]  bent back

**Head rest position:** [ ]  lowest positon [ ]  middle position [ ]  highest position

**Seatback position:** [ ]  straight up-right [ ]  slight recline [ ]  full recline

**Did any part of your body strike anything inside of your car**: [ ]  Yes [ ]  No

**If Yes** what body part / what area of the car? \_\_\_\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Were any inside parts of your vehicle displaced or broken**: Yes [ ]  No [ ]

If yes list:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Were any personal items displaced or broken**: Yes [ ]  No [ ]

If yes list:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Did you experience**: [ ] Shock [ ] Loss of Consciousness [ ] Whiplash [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Describe Collision**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Draw a picture / Diagram of collision:**

**Immediate Law Enforcement** following the collision: *(Mark a ✓ on each that applies)*

[ ]  Police were called [ ]  Police showed to the scene

[ ]  No police, we just exchanged information [ ]  Hit & Run, no information to exchange

­­[ ]  I was ticketed for the accident [ ]  Other party was ticketed

[ ]  A Police report was done at the scene [ ]  I filed a police report on my own

[ ]  I have copy of the police report

Police Department: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Officer’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Witnesses:**

Was anyone else in the car with you**:** [ ]  Yes [ ]  No (If yes Who?):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did any other person witness the accident? [ ]  Yes [ ]  No: (if Yes who?):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Immediate Medical** **help** following the collision: *(Mark a ✓ on each that applies)*

[ ]  Ambulance / Paramedics were called

[ ]  I was treated at the scene

[ ]  I was transported to Hospital by Ambulance

[ ]  Even though offered transport I opted not to: Why?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  I went to the Hospital in my own / via friend / via family. When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  X-rays / MRI were done at Hospital: What body area: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Medication was prescribed by the Hospital: What; \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Follow-up care was recommended: What: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Ambulance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Hospital; \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Other doctors SEEN FOR THIS COLLISION before coming to this office:**

[ ]  Orthopedist [ ]  Neurologist [ ]  Psychiatrist [ ] Physiatrist [ ]  Chiropractor

[ ]  Acupuncturist [ ]  General Practitioner [ ]  Physical Therapist [ ]  Massage Therapist

[ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If so give:**

Clinic name Practitioner’s Name Phone number Approximate Date(s) seen \_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Symptomatology: (Pain characteristics for MAJOR area(s) of complaint) FROM THIS COLLISION**

Please use the legend symbols below to accurately mark the areas in which you feel thesesensations:

 Stabbing: SSSS Tingling-TTTT Burning-BBBB Cramping-CCCC

 Numbness-NNNN Dull- DDDD Achy: AAAA Pin/ Needles: PPPP



**(Muscle – Skeletal) :**

***Mark a ✓*** **on symptoms that have resulted DUE TO THIS COLLISION**

***Mark a X* on symptoms that you had PRIOR but made WORSE DUE TO THIS COLLISION**

 [ ]  Headaches/ Migraines [ ]  Wrist/ Carpal Tunnel [ ]  Leg/ Calf Pains

 [ ]  Neck Pain [ ]  Inside the Shoulder Pain [ ]  Chest Pain

 [ ]  Top of Shoulder Pain [ ]  Elbow/ Arm Pain [ ]  Abdomen Pain

 [ ]  Mid-Back Pain [ ]  Hand / Fingers Pain [ ]  Problem Sleeping

 [ ]  Along Shoulder Blades [ ]  Hip Pain [ ]  Numbness in Arms/ Hands

 [ ]  Low Back Pain [ ]  Knee Pain **[ ]** Numbness in Legs/ Feet

 [ ]  Sacrum Pain [ ]  Foot/ Ankle/ Toes [ ]  Jaw Pain / clicking

**(Cognitive / Emotional/ Sensory) :**

***Mark a ✓*** **on symptoms that have resulted DUE TO THIS COLLISION**

***Mark a X* on symptoms that you had PRIOR but made WORSE DUE TO THIS COLLISION**

[ ]  Ringing in Ear [ ]  Vertigo/ Dizziness [ ]  Loss of Balance [ ]  Fatigued [ ]  Black outs [ ]  Difficulty Concentrating [ ]  Loss of memory [ ]  Vison changes [ ]  Reading Problem [ ]  Sensitivity to Light [ ]  Sensitivity to Sound [ ]  Anxiety [ ]  Highly Emotional [ ]  Irritability [ ]  Apathy [ ]  Depression [ ]  Social withdrawn [ ]  Loss of Taste [ ]  Loss of Smell [ ]  Loss of Hearing [ ]  Difficulty in Speech [ ]  Night mares [ ]  Sensitivity Hot / Cold

[ ]  Loss of Libido [ ]  Thoughts of Suicide [ ]  Typing / Writing Problems

**(Systematic):**

***Mark a ✓*** **on symptoms that have resulted DUE TO THIS COLLISION**

***Mark a X* on symptoms that you had PRIOR but made WORSE DUE TO THIS COLLISION**

[ ]  Asthma [ ]  Digestive Problems [ ]  Allergies **[ ]** Shortness of Breath [ ]  Extreme Thirst [ ]  Weight Loss /Gain [ ]  Nausea / Vomiting [ ]  Menstrual Irregularities [ ]  High Blood Pressure

**(Miscellaneous):**

[ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Self-Care:**

**What do you do for yourself to relieve any the symptoms?** (*(Mark a ✓ on each that applies)*

[ ]  Take Non-Prescription / over the counter Medications

[ ]  Take prescription Medications

[ ]  Recreational drugs

[ ]  Use ice

[ ]  Use heat

[ ]  Get extra Rest / sleep

[ ]  Do Stretches

[ ]  Do Exercises

[ ]  Massage self

[ ]  Massage from family member / friend

[ ]  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Effects of your injuries / symptoms:***

***Please mark a ✓ on each that applies to your activities affected by injuries due to this collision:***

[ ]  Have to hold onto something to sit or stand from a chair.

[ ]  Stay at home most of the time.

[ ]  Have to sit most of the day.

[ ]  Stays in bed most of the day.

[ ]  Change position frequently to try and get comfortable.

[ ]  Have difficulty turning over in bed.

[ ]  Have to lie down and rest frequently.

[ ]  Have to get other people to do things for me.

***Please mark a ✓ on each that applies to Difficulties you are having in your daily activities affected by injuries due to this collision:***

[ ]  Driving the car [ ]  Bathing self [ ]  Going to Restroom [ ]  Climbing Stairs [ ]  Walking [ ]  Dressing Self

[ ]  Brushing teeth [ ]  Combing Hair [ ]  Shaving

[ ]  Doing Laundry [ ]  Ironing [ ]  Cooking [ ]  Vacuuming [ ]  Washing Dishes [ ]  Dusting [ ]  Movie going [ ]  Dining Out [ ]  Shopping

[ ]  Kneeling [ ]  Social events [ ]  Going to Church.

[ ]  Sexual relationships [ ]  Reading [ ]  Watching TV

[ ]  Child care [ ]  Using phone [ ]  Computer work

[ ]  Mowing Lawn [ ]  Gardening [ ]  Washing Car

[ ]  House Maintenance [ ]  Landscaping [ ]  Taking out Trash

[ ]  Aerobic exercising [ ]  Backpacking [ ]  Basketball [ ]  Bowling [ ]  Boxing [ ]  Bicycling [ ]  Basketry [ ]  Baseball [ ]  Fishing

[ ]  Fencing [ ]  Dancing [ ]  Camping

[ ]  Card Playing [ ]  Handball [ ]  Golf

[ ]  Football [ ]  Judo [ ]  Hunting

[ ]  Hockey [ ]  Health Club [ ]  Gymnastics

[ ]  Yoga [ ]  Petitioning [ ]  Karata

[ ]  Ice Skating [ ]  Horseback riding [ ]  Sailing

[ ]  Rafting [ ]  Racquetball [ ]  Photography

[ ]  Jogging [ ]  Swimming [ ]  Snow Skiing

[ ]  Sewing [ ]  Weightlifting [ ]  Water sports

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How do the following positions or motions affect your pain?**

No Change Relieves Increased If increases Duration limited to?

Sitting [ ]  [ ]  [ ]  \_\_\_\_\_\_\_\_ hours / minutes

Walking [ ]  [ ]  [ ]  \_\_\_\_\_\_\_\_ hours / minutes

Standing [ ]  [ ]  [ ]  \_\_\_\_\_\_\_\_ hours / minutes

Lying Down [ ]  [ ]  [ ]  \_\_\_\_\_\_\_\_ hours / minutes

Looking up [ ]  [ ]  [ ]  \_\_\_\_\_\_\_\_ hours / minutes

Looking Down [ ]  [ ]  [ ]  \_\_\_\_\_\_\_\_ hours / minutes

Lifting [ ]  [ ]  [ ]  \_\_\_\_\_\_\_\_ weight / repetitions

Bending [ ]  [ ]  [ ]  \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_

**Employment History / Change**

Were you employed at the time of the collision?: YES [ ]  NO [ ]

did you loose your job due to this collision?: YES [ ]  NO [ ]

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Company name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supervisor / Boss name; \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your job Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your job Duties: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Loss time from work due to this collision?: YES [ ]  NO [ ]

If yes:

Day: Date: Amount of time:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Has /Have you and or your Boss modified any your work responsibilities due to the effects of this collision? YES [ ]  NO [ ]

if so explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Other doctors seen NOT FOR / BEFORE this collision:**

[ ]  Orthopedist [ ]  Neurologist [ ]  Psychiatrist [ ] Physiatrist [ ]  Chiropractor

[ ]  Acupuncturist [ ]  General Practitioner [ ]  Physical Therapist [ ]  Massage Therapist

[ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If so give:**

Clinic name Practitioner’s Name Phone number Date(s) seen \_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Prior Medical History:**

List medical conditions you have been treated for **outside of and /or before** conditions due to this car collision:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List Past Surgeries:** [ ]  None

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**List current medications:** [ ]  None \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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I verify I have reviewed pages 1 through10 of this Auto Collision / Personal Injury Intake form and the information I have provided is to the best of my abilities factual / accurate.

**Name Printed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature Date**