

Motor Vehicle Injury Information

Name: _____ Date: _____

Date & Location of Accident: _____

Were you the Driver Passenger Pedestrian

If passenger, where were you seated? Front Seat Back Seat – Left
 Back Seat – Right Other _____

Where was the Impact? From Behind On the Right Side
 In the Front On the Left Side
 Other _____

Did your car strike anything? No Yes, What? _____

Did anything strike your car? No Yes, What? _____

Approximately how fast was the vehicle traveling at impact? _____ M.P.H
Type of Car: _____

Approximately how fast was the other vehicle traveling at impact? _____ M.P.H
Type of Car: _____

Did you see the Accident coming? No Yes
If yes, did you brace yourself in any way? No Yes

How were you seated? Facing Forward Body Turned Left / Right
 Head Tipped Up / Down Head Turned Left / Right
 Other _____

Where were your hands & feet? _____

Did any part of your body strike anything? _____
Did you ever become unconscious? No Yes

Were you wearing your seatbelt? No Yes
If yes, did you sustain any injuries as a result? _____

Did the airbag deploy? No Yes

Where was the headrest in relation to your head? Below / At / Above None

Were any traffic citations issued to you? No Yes

Did you seek medical attention? No Yes
If yes, Date & Location: _____

Name of Doctor: _____

Did they take X-rays? No Yes

Were you Hospitalized? No Yes, How long? _____

Diagnosis: _____

Treatments / Instructions / Medications given to you: _____

Please give any additional details of the accident: _____

What is your reason(s) for seeking treatment? _____

Please give any symptoms you've had since the accident: (check all that apply)

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> headache | <input type="checkbox"/> neck pain | <input type="checkbox"/> upper-back pain | <input type="checkbox"/> middle-back pain |
| <input type="checkbox"/> lower-back pain | <input type="checkbox"/> pelvic pain | <input type="checkbox"/> stiffness | <input type="checkbox"/> tension |
| <input type="checkbox"/> fatigue | <input type="checkbox"/> light-headedness | <input type="checkbox"/> dizziness | <input type="checkbox"/> fainting / black outs |
| <input type="checkbox"/> nausea | <input type="checkbox"/> irritability | <input type="checkbox"/> nervousness | <input type="checkbox"/> sleeping problems |
| <input type="checkbox"/> depression | <input type="checkbox"/> loss of smell | <input type="checkbox"/> loss of taste | <input type="checkbox"/> loss of sensation |
| <input type="checkbox"/> light sensitivity | <input type="checkbox"/> blurred vision | <input type="checkbox"/> sinus problems | <input type="checkbox"/> ringing in ears |
| <input type="checkbox"/> buzzing in ears | <input type="checkbox"/> jaw problems | <input type="checkbox"/> loss of memory | <input type="checkbox"/> loss of concentration |
| <input type="checkbox"/> face flushed | <input type="checkbox"/> loss of balance | <input type="checkbox"/> diarrhea | <input type="checkbox"/> constipation |
| <input type="checkbox"/> upset stomach | <input type="checkbox"/> cold sweats | <input type="checkbox"/> fever | <input type="checkbox"/> breathing problems |
| <input type="checkbox"/> chest pain | <input type="checkbox"/> joint pain | <input type="checkbox"/> extremity pain | <input type="checkbox"/> loss of strength |
| <input type="checkbox"/> cold feet | <input type="checkbox"/> cold hands | <input type="checkbox"/> finger / hand numbness | <input type="checkbox"/> toe / foot numbness |
| <input type="checkbox"/> pins & needles sensation in arms / hands | <input type="checkbox"/> pins & needles sensation in legs / feet | | |

Please list any other symptoms, not mentioned above, that you have noticed since the accident:

How has your life been affected since the accident? Not at all Some A Lot

Have you lost any days of work because of this? No Yes, How much? _____

Since the accident, have you had trouble with any of the following: (check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Getting ready for the day | <input type="checkbox"/> Getting ready for bed |
| <input type="checkbox"/> Driving | <input type="checkbox"/> Household chores |
| <input type="checkbox"/> Work / School activities | <input type="checkbox"/> Sleeping |
| <input type="checkbox"/> Other _____ | |

Did you hire an Attorney? No Yes, Name: _____

Have you settled with the insurance company? No Yes

What is the name of the company? _____

Contact Person: _____

Phone Number for Verification: _____

Claim Number: _____

I, _____, have answered the above questions to the best of my ability and do hereby acknowledge that the answers I have given are completely true. I do hereby authorize Active Spine & Rehabilitation to treat me for the stated injury and agree to comply with their management plan. If I do not comply with the recommended plan, I agree that Active Spine & Rehabilitation is not responsible for my outcome. I realize that I may never get back to my pre-accident condition and will be treated to a point of maximum improvement. I agree to be responsible for all charges, regardless of the outcome of my personal injury claim. In the event that the responsible party does not compensate Active Spine & Rehabilitation, I will pay for such charges. If a check is issued to me, I am responsible for paying Active Spine & Rehabilitation the amount owed. I do hereby authorize a doctor's lien in the event that my attorney receives my settlement.

I understand the above statements and agree to the terms by signing below.

Signature _____ Date _____

Printed Name _____

Parent / Guardian's Signature (if minor or legally unable to consent) _____

Doctor's Signature _____ Date _____