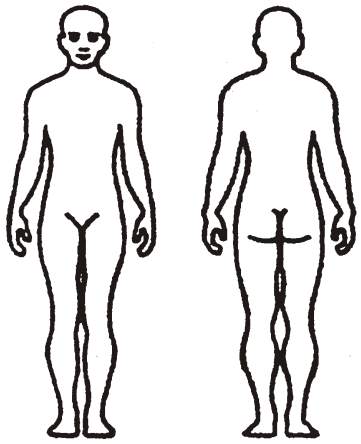
Please indicate all areas of pain on the diagram below

Extreme Pain

10
9
8
7
6
5
4
3
2
1

No Pain

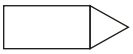


Do you CURRENTLY suffer with the following:

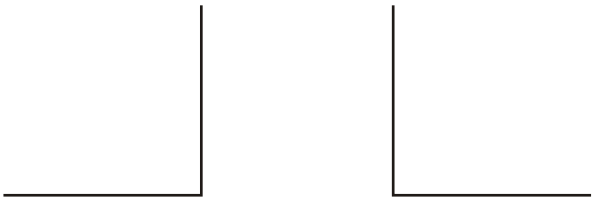
- ☐ Neck Pain
- ☐ Mid Back Pain
- ☐ Low Back Pain
- ☐ Headaches
- ☐ Dizziness
- ☐ Diabetes
- ☐ Arthritis
- ☐ Ashma
- ☐ Radiating Pain
- ☐ Digestive Disorder
- ☐ Nervousness
- ☐ Sinus trouble
- ☐ Heart Trouble

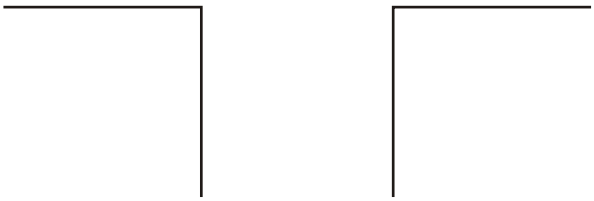
Please add any additional information regarding your symptoms (quality, timing, etc.)

Please indicate direction of vehicles

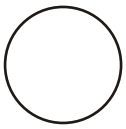


ACCIDENT SCENE MAP





Indicate North by an arrow



Please describe any additional information about the accident:

Print Name: _____

Signature: _____

Date: _____

IT IS IMPORTANT THAT YOU FILL IN THE FOLLOWING INFORMATION COMPLETLY, IF YOU HAVE ANY

QUESTIONS WE WILL BE HAPPY TO HELP YOU

FACT FINDING HISTORY & DISCUSSION

Name _____
Street _____
Town./Zip _____
Phone # _____ SS # _____
Date of Birth _____ Age ____

Place of Employment _____
Street _____
Town/Zip _____
Phone # _____
Job Description _____

MEDICAL HEALTH INSURANCE

Name of Health Ins. _____
ID # _____ Phone # _____
If you do not have medical insurance please sign the Health Ins. Affidavit

OWNER'S AUTO INS. INFO

Name _____
Auto Ins. Co _____
Name if Ins. Agent _____
Phone# _____

Are you currently being represented by an Attorney? Y / N If yes, please complete the Attorneys information

ATTORNEY INFORMATION

Name _____
Street _____
Town/ZIP _____
Phone# _____

PLEASE ENTER THE REQUIRED INFORMATION OR CIRCLE Y OR N

Date of your accident? _____ City/State in which it occurred? _____ Time _____ am/pm

Were you wearing your seatbelt? Y/N Was the accident a surprise? Y / N Were there any secondary impacts? Y / N

What part of your car was impacted? _____

How fast was your vehicle traveling (approx.)? _____ How fast were the other vehicles traveling (Approx) ? _____

Was your vehicle stopped? Y / N Describe the weather conditions _____ Did you go to the hospital Y / N

If yes, which hospital? _____ Did you have x-rays? Y / N Medication? Y / N

If yes, what Meds. were prescribed? _____

How did you get to the hospital? _____

Other than the ER, any other doctors seen? _____

Was your accident reported to the police? Y / N. Is the police report available? Y / N

How was your general health at the time of the accident? _____

Have you ever been involved in an auto accident before? Y / N. If yes, when? _____

Have you ever had surgery? Y / N. If yes, please explain _____

At the time of the accident: Where you dazed? Y / N. Did you lose Consciousness? Y / N

Are there any medical conditions that require special attention? Y / N. If yes, explain _____

Have you lost any time from work? Y / N. If yes, how please explain?_____

Any cuts, bruises, broken bones, bleeding? Y / N. If yes, please explain _____

Are you in pain when you; Sit___ Stand___ Drive___ Exercise___ Work___ Sleep___

What percentage of the day are you affected (please circle)? 25% 50% 75% 100%

Please complete the back side of this form.