110 PRIOR SIMILAR SYMPTOMS

10 Did you have any physical complaints just before the accident? ☐ No

20 If yes, what physical symptoms did you have just before the accident? ______________________________

____

30 PRIOR to this accident, have you EVER had symptoms similar to what you're experiencing now? ☐ No

40 If yes, please explain *(briefly include past falls, injuries, accidents, operations, etc.)*. ______________________________

____

120 ACTIVITIES OF DAILY LIVING

10 Do you notice any activities of your **home** daily routines that are different **now** than from **before** the accident? ☐ No

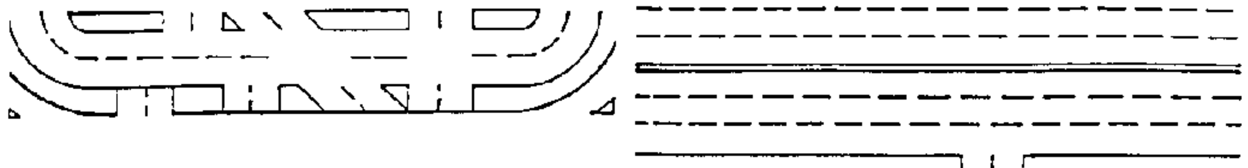
20 If yes, list them as:

30 Those activities that you are **now unable** to do are *(be specific)*: ______________________________

40 Those activities that are **now painful** to do are *(be specific)*: ______________________________

50 Those activities that are **now difficult** to do are *(be specific)*: ______________________________

INDICATE ON THESE DIAGRAMS HOW THE ACCIDENT HAPPENED



ATTORNEY ON CASE

Do you have an attorney on this case? ☐ No

If yes who? Name ______________________________

Address ______________________________ City ______________ State ________ Zip ____________

Patient Signature: X ______________________________ **Date** ______________

AUTOMOBILE ACCIDENT — INSURANCE DATA

Patient's Insurance Company Information

Company Name: ______________________ PH: ______________ Policy #: ______________

P.O. Box/Street Number ______________________________ Adjuster's Name: ______________

City/State/Zip: ______________________________

Insured's Insurance Information

Insured's name if other than patient: ______________________________ PH. ______________

Company Name: ______________________ PH: ______________ Policy #: ______________

P.O. Box/Street Number. ______________________________ Adjuster's Name ______________

City/State/Zip: ______________________________

Other Driver's Insurance Information

Other Driver's Name (if another car was involved): ______________________________ PH: ______________

Company Name. ______________________ PH: ______________ Policy #: ______________

P.O. Box/Street Number: ______________________________ Adjuster's Name: ______________

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