Please fill out this form completely and legibly. Leave nothing blank.
If something does not apply, write "N/A" on the line.

Name_____ Date of Birth _____ Today's Date _____
Date of Accident_____ Time of Accident _____

Your Vehicle:
Year _____ Make_____ Model _____
Your Speed _____ Damage to Vehicle $ _____
Your Insurance Co. _____
Your Policy Number _____
PIP Claim Number _____
Adjuster_____
Adjuster's Phone _____
Have you retained an Attorney? ❑ Yes ❑ No
Attorney's Phone _____

Other Vehicle:
Year _____ Make _____ Model_____
Their Speed_____ Damage to Vehicle $ _____
Their Insurance Co._____
Liability Claim Number _____
If yes, Attorney's Name_____
Attorney's Address _____

Describe how the accident happened: _____
_____
_____
_____
_____

Accident Specifics (Check all that apply)

You were the:	❑ Driver	❑ Passenger		
In a:	❑ Two door coupe	❑ Four door sedan	❑ SUV	❑ Pickup
	❑ Motorcycle	❑ Other _____		
Sitting in the:	❑ Front seat	❑ Back seat		
Wearing:	❑ Seat belt	❑ No Seat belt	❑ Helmet	❑ No Helmet
You were heading:	❑ North	❑ South	❑ East	❑ West
	Name of Street or Highway: _____			
Other vehicle was heading:	❑ North	❑ South	❑ East	❑ West
	Name of Street or Highway: _____			
The road was:	❑ Dry	❑ Wet	❑ Icy	❑ Snowy
The weather conditions:	❑ Sunny	❑ Cloudy	❑ Foggy	❑ Snowing
	❑ Light rain	❑ Heavy rain		
Impending collision:	❑ Aware	❑ Unaware	❑ Braced	❑ Not braced
You were struck from:	❑ Behind	❑ Front	❑ Left side	❑ Right side
You were heading:	❑ North	❑ South	❑ East	❑ West
Did your head:	❑ Strike an object	❑ Not strike an object	❑ Break glass	
In relation to the back of your head, was your headrest set:		❑ Low	❑ Middle	❑ High
Where was your head facing at the time of impact?		❑ Left	❑ Forward	❑ Right
Were you leaning forward at the time of impact?		❑ Yes	❑ No	
Did you experience:	❑ Shock	❑ Flash of light seen	❑ Loss of consciousness	
Did the airbag deploy?	❑ Yes	❑ No		
Were the police notified?	❑ Yes	❑ No		

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Immediately following the accident:
- ❑ Ambulance (Paramedics Called)
- ❑ Transported to Hospital by Ambulance
- ❑ Diagnostics performed at Hospital
- ❑ Medication Prescribed,
- ❑ Treated at scene
- ❑ Went to Hospital on own
- ❑ Treated at Hospital
- ❑ Follow up recommended

State your emotions and physical state **Immediately** following the accident: _____

_____

_____

State your emotions and physical state **After the first few days**: _____

_____

_____

Other Doctors seen:

❑ Orthopedist, Name _____
Diagnosis _____ Treatment _____
❑ Neurologist, Name _____
Diagnosis _____ Treatment _____
❑ Massage Therapist, Name _____
Diagnosis _____ Treatment _____
❑ Physical Therapist, Name _____
Diagnosis _____ Treatment _____
❑ Psychiatrist/Psychologist, Name _____
Diagnosis _____ Treatment _____
❑ Other, Name _____
Diagnosis _____ Treatment _____

Pain characteristics for the major area of complaint:

The pain started: _____
The pain is made better by: _____
The pain is made worse by: _____

The pain has the following qualities:

❑ There is ❑ There is not Radiation into _____
❑ There is ❑ There is not Referred pain into _____
❑ There is ❑ There is not Parasthesia (Tingling/Numbness) into _____

The pain is located _____
The pain is (as far as timing is concerned: i.e. Comes and goes, constant, etc…) _____

_____

Have you ever had any complaints in the involved area before? ❑ Yes ❑ No
If Yes, what were the complaints? _____
Before the injury, were you capable of working on equal basis with others your age? ❑ Yes ❑ No
Are your work activities restricted as a result of this accident? ❑ Yes ❑ No
Since this injury, are your symptoms: ❑ Improving ❑ Getting worse ❑ The same