Auto Accident Patient Information | CONFIDENTIAL

First Name _____ Last Name _____

Date of Accident _____ Today's Date _____

Please describe the accident: _____

_____

_____

_____

What other care have you received for your injuries related to this accident? _____

_____

_____

Were you the driver at fault?	☐Yes ☐No	Did you visit a hospital?	☐Yes ☐No
Was a citation issued?	☐Yes ☐No	Were x-rays taken?	☐Yes ☐No

Please complete the following information regarding your automobile insurance coverage:

Insurance Company Name _____

Policy #_____ Claim # _____

Claims Address _____

_____

Representative Name _____ Phone_____

Do you have Med Pay on your policy? _____ In what amount? _____

If another party is responsible, please be aware that, by Colorado state law, they don't have to pay us directly, and may wait until you have completed care to "settle" your claim. It is highly recommended that you seek an attorney to act in your best interests, and to "haggle" with the insurance adjuster. We will accept your case on a lien basis, please make sure you have read and understand the lien, before signing. If any of this information is missing or incomplete you will be required to pay us in full at the time of service.

Attorney's Name _____ Phone_____

Address _____

_____

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8791 Wolff CT Suite 140 Westminster, CO 80031
Phone: (303) 427-2414 | Fax: (303) 427-5719

Please answer these questions regarding YOU being in the automobile:

What was your position in the automobile? [circle one]

Driver Front Passenger Rear Passenger Left Rear Passenger Right

Which direction were you looking at the moment of impact? [circle one]

Forward Right Left Backward

Did you foresee the accident before impact? ☐No ☐Yes

Were you restrained (wearing a seatbelt)? ☐No ☐Yes

Did your airbag deploy? ☐No ☐Yes

Do you recall hitting your head with the impact? ☐No ☐Yes: Where? _____

Did you lose consciousness during the accident? ☐No ☐Yes

Were you bruised from the accident? ☐No ☐Yes: Where? _____

If you were the DRIVER, please answer the following questions:

Which of your hands were on the steering wheel? ☐Right ☐Left ☐Both

Which of your feet were on a pedal? ☐Right ☐Left ☐Both

Did you feel that you lost control of the vehicle? ☐No ☐Yes

Please answer the following questions related to the AUTOMOBILE itself:

Where did the auto wreck occur? Street Intersection Highway Driveway Parking Lot

Was there impact damage to your car? _____

How would you rate the damage to your car? _____

If this automobile accident occurred between two cars (or among multiple cars):

Was **your car** stopped or in motion before the impact?_____

From which direction did **your car** impact the other car? _____

From which direction did **the other car(s)** impact your car? _____

Was (Were) **the other car(s)** stopped or in motion before the impact? _____

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Please answer the following questions regarding how you have felt since this automobile accident.
Circle One: 1=Not at all; 2=Seldom; 3=Sometimes; 4=Often; 5=Frequently.

Do you experience repeated, disturbing memories, thoughts or images of this auto accident?	1	2	3	4	5
Do you have repeated, disturbing dreams of this auto accident?	1	2	3	4	5
Do you experience yourself suddenly acting or feeling as if this auto accident were happening again (as if you were reliving it)?	1	2	3	4	5
Do you get upset when something reminds you of this auto accident?	1	2	3	4	5
Do you avoid thinking about or talking about this auto accident?	1	2	3	4	5

Do you have physical reactions (e.g., heart pounding, trouble breathing, sweating) when something reminds you of this auto accident, especially driving or being in an automobile since the accident?	1	2	3	4	5
Do you avoid driving or being in an automobile?	1	2	3	4	5
Do you have trouble remembering important details of the accident?	1	2	3	4	5
Have you lost interest in things and activities that you used to enjoy?	1	2	3	4	5
Do you feel distant or cut off from other people?	1	2	3	4	5
Do you feel emotionally numb or have you been unable to give or receive loving feelings to those who are close to you?	1	2	3	4	5
Do you feel as if your future will somehow be cut short?	1	2	3	4	5

Do you have trouble falling asleep or staying asleep?	1	2	3	4	5
Do you experience feeling irritable or having angry outbursts?	1	2	3	4	5
Do you have difficulty concentrating?	1	2	3	4	5
Do you feel “super alert” or watchful or on guard?	1	2	3	4	5
Do you feel jumpy or are you easily startled?	1	2	3	4	5

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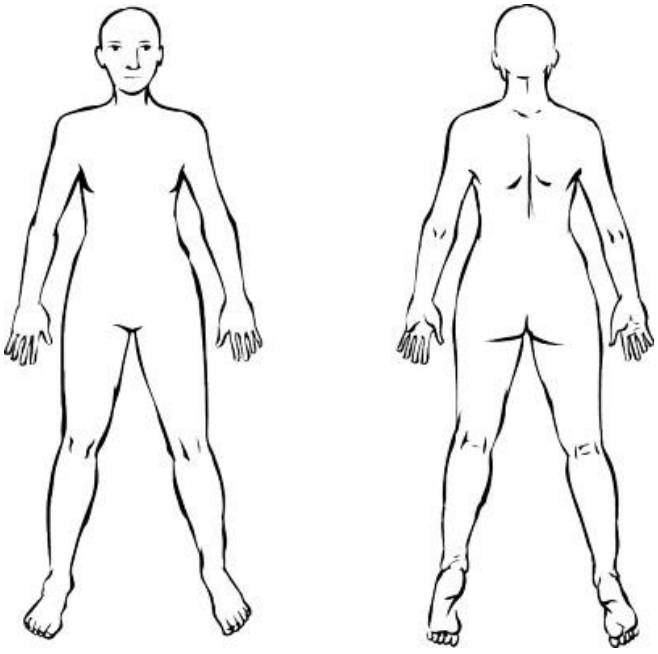

On the drawing, please indicate areas where you are experiencing symptoms

P to indicate **PAIN**

S to indicate **STIFFNESS**

W to indicate **WEAKNESS**

E to indicate **EDEMA [SWELLING]**

AREA OF FOCUS	**INTENSITY** [0=No Pain; 1-2-3 Low; 4-5-6 Mild; 7-8-9 Moderate; 10=Severe Pain]	**FREQUENCY** [Constant; Frequent; Random, &c; # of times per day, week, month, &c.]	**CHARACTER** [Describe how it feels; e.g., sharp, ache, burning, dull, tight, sore, numb, tingly, vice, &c.]
HEAD			
NECK/SHOULDER			
ARM/HAND			
MID BACK			
LOW BACK			
LEG/FOOT			
OTHER			

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