## PERSONAL INJURY INFORMATION SHEET:

**Patients Name:**_____

**DATE OF ACCIDENT:**_____ **TIME** _____ **AM PM**

**WHERE DID ACCIDENT HAPPEN?** _____

**Describe the accident in your own words:** _____

_____

**WERE YOU THE:** _____ **DRIVER** _____ **PASSENGER FRONT/BACK** _____**PEDESTRIAN**

**WERE YOU WEARING A SEATBELT: Y/N** ____**SHOULDER** ____**LAP** _____**BOTH**

**WERE YOU STRUCK FROM:** ____**BEHIND** ____**RT SIDE** ___**LT SIDE** ____**FRONT**

**WERE THE POLICE NOTIFIED? Y/N** **DID YOU GO TO THE HOSPITAL? Y/N**

INSURANCE INFORMATION:

**PRIMARY INSURANCE:** _____

**ADDRESS**_____

**CITY**_____ **STATE**_____ **ZIP**_____

**PHONE:**_____ **ADJUSTER:** _____

**CLAIM #** _____ **INSURED'S NAME:** _____

**SECONDARY INSURANCE:** _____

**ADDRESS:**_____

**CITY**_____ **STATE** _____ **ZIP** _____

**PHONE:** _____ **ADJUSTER:** _____

**CLAIM #:** _____ **INSURED'S NAME:** _____

**ATTORNEY:** _____ **PHONE:** _____

**PLEASE CHECK ANY SYMPTOMS THAT YOU HAVE EXPERIENCED SINCE THE ACCIDENT:**

___ HEADACHE
___ NECK PAIN
___ NECK STIFF
___ DEPRESSION
___ NERVOUSNESS
___ FACE FLUSHED
___ FAINTING SPELLS
___ DIARRHEA
___ CONSTIPATION
___ STOMACH UPSET
___ IRRITABILITY
___ CHEST PAIN
___ DIZZINESS
___ BACK PAIN
___ TENSION
___ FEET COLD
___ LOSS OF SMELL
___ HANDS COLD
___ COLD SWEATS
___ LOSS OF TASTE
____ BUZZING IN THE EARS
____ SHORTNESS OF BREATH
____ FATIGUE
____ SLEEPING PROBLEMS
____ HEAD SEEMS TO HEAVY
____ TINGLING IN ARMS
____ TINGLING IN LEGS
____ FINGERS NUMB
____ NUMBNESS IN TOES
____ LOSS OF BALANCE

PLEASE DESCRIBE YOUR ACCIDENT ON REVERSE IN DETAIL (INCLUDE A SIMPLE DIAGRAM)***