

CONFIDENTIAL PATIENT INFORMATION  
AUTO

Date \_\_\_\_\_

Legal Name \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_

Address (No. & St.) \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Social Security No.: \_\_\_\_\_ Birthdate \_\_\_\_\_

Employer: \_\_\_\_\_ Address: (No. & St.): \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Employer phone ( ) \_\_\_\_\_

Cal Drivers Lic. No.: \_\_\_\_\_ Spouse's name \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Date of Accident \_\_\_\_\_ Time (approx) \_\_\_\_\_ AM PM

You were traveling N S E W on \_\_\_\_\_ St. and you were struck from BEHIND / FRONT / LEFT SIDE  
RIGHT SIDE by a vehicle traveling N S E W on \_\_\_\_\_ St., City of \_\_\_\_\_

You were STOPPED / TRAVELING approx \_\_\_\_\_ MPH. Other driver was STOPPED / TRAVELING approx \_\_\_\_\_ MPH.

You were driving a \_\_\_\_\_ Other vehicle was a \_\_\_\_\_

Damage to your vehicle was (approx) \$ \_\_\_\_\_ Vehicle is registered to \_\_\_\_\_

You were the DRIVER / PASSENGER / BACK SEAT. You were wearing SHOULDER HARNESS / LAP BELT / NO RESTRAINTS  
Air bag DID / DID NOT deploy. Police report WAS / WAS NOT made.  
You DID / DID NOT see the accident about to happen. Your foot was on the BRAKE / GAS PEDAL when the accident occurred.  
You were looking FORWARD / TO THE RIGHT / TO THE LEFT when the accident occurred.  
Were you thrown about in the car? YES / NO. Did you hit the steering wheel? YES / NO. The windshield? YES / NO.

You were taken to \_\_\_\_\_ Hospital/ Clinic in the city \_\_\_\_\_ following the accident,  
where you received MEDICATION / XRAYS / MRI / OTHER \_\_\_\_\_

- OTHER
1. You continued your day as usual
  2. You went home to rest.
  3. You were taken to a friend's house
  4. \_\_\_\_\_

Immediately following the accident you felt

- |                        |                            |                               |                     |
|------------------------|----------------------------|-------------------------------|---------------------|
| SHOCK                  | NECK PAIN                  | HEADACHE                      | LOW BACK PAIN       |
| TINGLING IN HANDS      | SHOULDER PAIN RIGHT / LEFT | DIZZINESS                     | VISUAL DISTURBANCES |
| CHEST PAIN             | ELBOW PAIN RIGHT / LEFT    | WRIST PAIN RIGHT / LEFT       | TINGLING IN FEET    |
| KNEE PAIN RIGHT / LEFT | SHALLOW BREATHING          | LOST CONSCIOUSNESS : YES / NO |                     |

OTHER \_\_\_\_\_

The next day you felt \_\_\_\_\_

Today your worst pain is \_\_\_\_\_

Have you seen your primary care or another doctor about this condition? YES NO.

If yes, name of doctor \_\_\_\_\_ in the city of \_\_\_\_\_

He/she recommended \_\_\_\_\_

OVER PLEASE