AZ MEDICAL AND SPORTS REHAB

Automobile Accident History

Form # ___ Date _____ Patient ID _____

Last Name _____ First Name _____ MI _____

Birthdate _____ Age _____ Email _____

Would you like to receive emails about specials and upcoming events? ☐ Yes ☐ No

Address_____

City _____ State _____ Zip _____

Phone (H)_____(W)_____(C)_____

Occupation _____ Employer _____

Spouse's Name _____ Employer _____

Emergency Contact Name _____ Phone _____

How did you hear about us? ☐ Walk In ☐ Social Media ☐ Event ☐ Yelp ☐ Google

☐ Referred by _____ ☐ Other _____

Primary Care Physician _____ Date of last exam _____

Address_____

City _____ State ____ Zip _____ Phone _____

Date of Accident: _____ Was the accident on the job? ☐ Yes ☐ No

Time of Accident: _____ am / pm ☐ Daylight ☐ Dawn ☐ Dusk ☐ Dark

Were you in a company vehicle? ☐ Yes ☐ No

Where were you seated in the vehicle? ☐ Driver ☐ Passenger ☐ Rear Passenger ☐ Other _____

Did you experience a flash of light or explosion in your head? ☐ Yes ☐ No

Did you lose consciousness upon impact? ☐ Yes ☐ No

Did the police come to the accident scene? ☐ Yes ☐ No Is there a police report? ☐ Yes ☐ No

Cause of injury? _____

Did you come in contact with the interior of the vehicle? ☐ Yes ☐ No

If so, which body part and what part of the vehicle? _____

Did you receive an injury to head? ☐ Yes ☐ No

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Your Information

Car Make _____ Model _____ Year _____ Speed _____

Where was your vehicle impacted? _____

What direction was your vehicle moving?

☐ Forward ☐ Reverse ☐ Stopped ☐ Turning left ☐ Turning right

How much damage did the vehicle receive? ☐ None ☐ Moderate ☐ Heavy

Was your vehicle towed from the scene? ☐ Yes ☐ No

At Fault Party Information

Car Make _____ Model _____ Year _____ Speed _____

What direction was the other vehicle moving?

☐ Forward ☐ Reverse ☐ Stopped ☐ Turning left ☐ Turning right

How much damage did the other vehicle receive? ☐ None ☐ Moderate ☐ Heavy

How much damage estimate for other vehicle? _____

Your Information

Name of the driver of the vehicle you were in _____

Name of their auto insurance _____

Policy # _____ **Claim #** _____

Insurance Adjuster Name _____ **Phone** _____

Have you retained an attorney? ☐ Yes ☐ No

Name _____ **Phone** _____

At Fault Party Information

Name of the driver _____

Name of their auto insurance _____

Policy # _____ **Claim #** _____

Insurance Adjuster Name _____ **Phone** _____

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Were Emergency Medical Services at the scene? ☐ Yes ☐ No

Describe the discomfort felt at time of accident. _____

_____

Where did you feel the symptoms?_____

_____

At the time of the accident, did you become or experience any of the following?

☐ Confused ☐ Disoriented ☐ Light headed ☐ Dizzy ☐ Nauseated ☐ Blurred vision

☐ Ringing/Buzzing in ears ☐ Loss of balance ☐ Other _____

_____

Did you go to the hospital? ☐ Yes ☐ No Where you X-Rayed? ☐ Yes ☐ No

Which hospital?_____

What was your diagnosis? _____

How did the hospital treat your injuries?_____

_____

Do you still have any of the symptoms you named above? ☐ Yes ☐ No

If yes, which ones? _____

Please check the symptoms you have noticed since the accident below:				
☐ Headache	☐ Neck Pain	☐ Upper Back Pain	☐ Shoulder Pain	☐ Mid-back Pain
☐ Low Back Pain	☐ Depression	☐ Buzzing In Ears	☐ Arm/Leg Pain	☐ Jaw Pain/Clicking
☐ Dizziness	☐ Fatigue	☐ Loss of Memory	☐ Cold Hands/Feet	☐ Numbness/Tingling
☐ Loss of Smell	☐ Irritability	☐ Digestive Problems	☐ Joint/Stiffness	☐ Menstrual Problems
☐ Pinched Nerves	☐ Loss of Sleep	☐ Loss of Balance	☐ Chest Pain	☐ Light Bothers Eyes
☐ Fever	☐ Nervousness	☐ Vision Problems	☐ Urinary Problems	☐ Sleeping Problems
☐ Paralysis	☐ Tension	☐ Fainting	☐ Pins/Needles Feeling	☐ Stomach Upset
☐ Difficulty Swallowing	☐ Sciatica	☐ Sinus Pain	☐ Sore Muscles	☐ Head Feels Too Heavy

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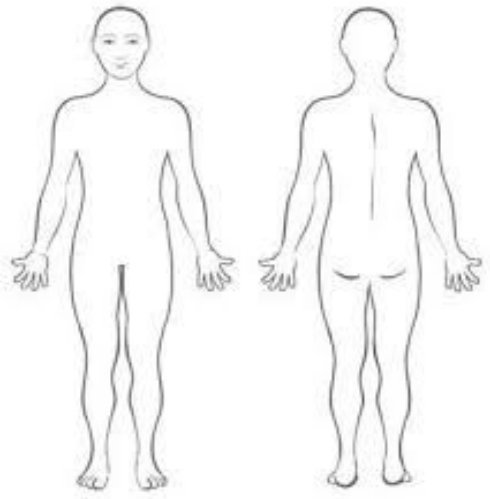
Current Complaints

List current symptoms separately in order of severity.



1st Body Part: _____

Date Symptom first appeared: _____

How often do you experience these symptoms?

☐ Constant ☐ 100% ☐ Frequent 75% ☐ Intermittent 50%

☐ Occasional 25% ☐ Rare 10%

What makes Symptom increase?_____

What makes symptom decrease?_____

Type of pain?

☐ Sharp ☐ Dull ☐ Aching ☐ Burn ☐ Throb ☐ Numb ☐ Other:

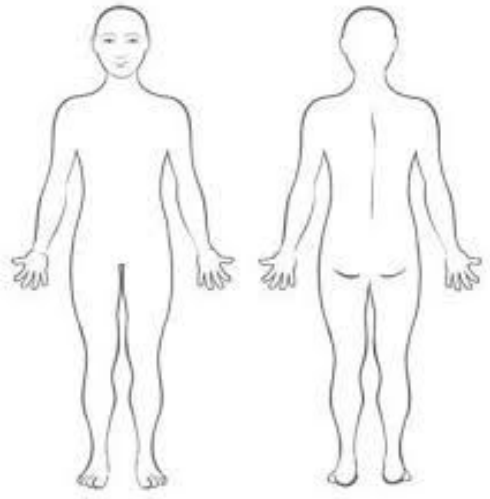
_____

Please rate the intensity of your symptoms (0 being no symptoms, 10 being extreme)

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Where does the pain radiate to? _____

2nd Body Part: _____



Date Symptom first appeared: _____

How often do you experience these symptoms?

☐ Constant ☐ 100% ☐ Frequent 75% ☐ Intermittent 50%

☐ Occasional 25% ☐ Rare 10%

What makes Symptom increase?_____

What makes symptom decrease?_____

Type of pain?

☐ Sharp ☐ Dull ☐ Aching ☐ Burn ☐ Throb ☐ Numb ☐ Other:

_____

Please rate the intensity of your symptoms (0 being no symptoms, 10 being extreme)

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Where does the pain radiate to? _____

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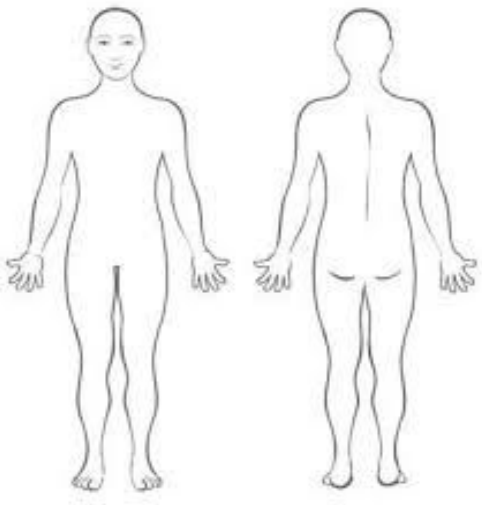

3rd Body Part: _____

Date Symptom first appeared: _____

How often do you experience these symptoms?

☐ Constant ☐ 100% ☐ Frequent 75% ☐ Intermittent 50%

☐ Occasional 25% ☐ Rare 10%

What makes Symptom increase?_____

What makes symptom

decrease?_____

Type of pain?

☐ Sharp ☐ Dull ☐ Aching ☐ Burn ☐ Throb ☐ Numb ☐ Other:

_____

Please rate the intensity of your symptoms (0 being no symptoms, 10 being extreme)

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Where does the pain radiate to? _____

Please list any medications or vitamins you are currently taking (including dosage)

1_____ Frequency_____ Dosage_____

What is this for? _____

2_____ Frequency_____ Dosage_____

What is this for? _____

3_____ Frequency_____ Dosage_____

What is this for? _____

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X-RAY CONFIRMATION

At this time, to the best of my knowledge, I am not pregnant and I consent to radiographic pictures if necessary.

_____ _____

Patient Signature Date

I understand the information contained within this form and guarantee it was completed correctly and to the best of my knowledge.

_____ _____

Patient Signature Date

AUTHORIZATION FOR CARE OF MINOR CONSENT TO TREAT A MINOR

I hereby authorize the doctor(s) at Arizona Medical and Sports Rehab and whomever they designate as assistants to administer care to a child.

Name of Minor Patient _____

Parent name_____

_____ _____

Parent Signature Date