Dynamic Health Wellness & Rehabilitation Center
Auto Accident Form

PATIENT INFORMATION		
Name: Last:	First:	M.I.
Address: Street:	City:	State, Zip:
Social Security #: -- --	State:	Zip:
Date of Birth -- --	Gender:	Marital status S ___ M___ D____ W___
Contact Information: Home Phone:	Office:	Cell:
Email :		
Employer Name:	Phone:	Fax:
Address:		
City:	State:	Zip:
Auto Insurance Company:		
Name:		
Representative:	Phone:	Fax:
Address:		
Claim Number:		
Accident Date:		
Attorney Information: Name:		Phone:
Address:		State, Zip:

Accident Questionnaire:

1.Were you the:☐ Driver ☐ Front Passenger ☐ Rear passenger
2.Make and model of the vehicle you were occupying______________________________
3.If a traffic violation was issued, to whom was it issued?______________________________
4.Number of people in accident vehicle?______________________________
5.Did the police come to the accident site? ☐ Yes ☐ No
6.Was a police report filed? ☐ Yes ☐ No
7.Were there any witnesses? ☐ Yes ☐ No
8.Were you wearing a seat belt? ☐ Yes ☐ No
9.Was this vehicle equipped with airbags? ☐ Yes ☐ No
If yes, did it/ they inflate? ☐ Yes ☐ No
10. What did your vehicle impact? ☐Another Vehicle ☐ Other______________________________
11. Did any part of your body strike anything in the vehicle? ☐ Yes ☐ No
If Yes. Please describe:______________________________
12. Make and model of the vehicle you were occupying?______________________________
13. Name of the location/ street on which you were traveling?______________________________
14. In which direction were you headed? ☐ N ☐ S ☐ E ☐ W
15. What was the approx. speed of your vehicle?______________________________
16. Did the impact to your vehicle come from the:
☐ Front ☐ Rear ☐ Right Side ☐ Left Side
17. During impact, were you facing: ☐Right ☐ Left ☐ Forward
18. Were you ☐ aware or ☐ surprised by the impact?
19. In your words, please describe the accident:______________________________

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After Accident:

1. Did accident render you unconscious? ☐Yes ☐ No
   If yes, for how long? ______________________________________
2. Please describe how you felt immediately after the
   accident:____
3. Have you gone to a hospital or seen any other Doctor? ☐ Yes ☐ No … If yes when did you go? ☐ Just after accident ☐ the next day ☐ 0 2 days ☐ Week or Later
   How did you get there? ☐ Ambulance ☐ Private Transportation
4. Name of hospital and/ or attending doctor:____________________________
5. Describe any treatment you received:_______________________________
6. Were X-Rays taken? ☐Yes ☐ No
7. Was medication prescribed? ☐ Yes ☐ No If Yes Please
   List:____
8. Have you been able to work since this injury? ☐ Yes ☐ No
9. Are your work activities restricted as a result of this injury? ☐ Yes ☐ No

Please indicate your symptoms that are a result of this accident:

☐ Neck Pain
☐ Shoulder Pain (R___ L___)
☐ Pain in Upper Arm or Elbow (R___ L___)
☐ Hand Pain (R___ L___)
☐ Pain in Wrist (R___ L___)
☐ Upper Back Pain (R___ L___)
☐ Lower Back Pain (R___ L___)
☐ Pain in Lower Leg (R___ L___)
☐ Pain in Upper Leg (R___ L___)
☐ Pain in Hip (R___ L___)
☐ Pain in Knee (R___ L___)
☐ Jaw Pain (R___ L___)
☐ Pain in Ankle or Foot (R___ L___)
☐ Headache

☐ Dizziness
☐ Memory Loss
☐ Blurred Vision
☐ Buzzing in ear
☐ Ears Ringing
☐ Difficulty Sleeping
☐ Irritability
☐ Fatigue
☐ Tension
☐ Jaw Problems
☐ Upset Stomach
☐ Nausea
☐ Numbness Where?_____________

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Where specifically are your symptoms located?____
Is your condition getting better, worse, or staying the same?____________________________________ ____ Which activities are difficult to perform? ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying down ☐ Other Are your symptoms: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other ______________________________ Rate the severity of your symptoms. (0= none to 10 = severe/unbearable) 0 1 2 3 4 5 6 7 8 9 10 Are your symptoms (% of the day)? ☐ Constant (90-100%) ☐ Frequent (50-75%) ☐ Intermittent (25-50%) ☐ Rare (<25%)
What makes your symptoms worse?
What makes your symptoms better?
What treatment(s) have you received for your condition: ☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Other
How tall are you? _____' _____" What is your present weight? _____ lbs.
How Did you hear about Dynamic Health Wellness & Rehabilitation Center?

Please read and sign the following:

- I certify that the above information is true and correct to the best of my knowledge. I agree to notify the doctor and or staff immediately whenever I have a change of information or in my health condition.
- I consent to the release of my confidential and patient information in the possession of Dynamic Health Wellness & Rehabilitation Center to other health care professionals whom I am referred and to the insurance company or other entity responsible for payment.
- I authorize Dynamic Health Wellness & Rehabilitation Center and their staff to perform any services needed during diagnosis and treatment. I also authorize payment of insurance benefits to Dynamic Health Wellness & Rehabilitation Center for services rendered.
- Our policy requires payment for services rendered at time of visit unless other arrangements have been made with the office manager. I understand that I am ultimately liable for all charges for services rendered.
- All HIPPA guidelines and requirements are followed in this office.

Signed (patient or authorized person)______________________________ **Date:**________________