Personal Injury Information
Shiloh Pain and Primary Care

Patient Information
Name:_____ DOB: _____

Auto Insurance Carrier Information
Carrier Name: _____ Policy #: _____

Address to submit claim: _____

City: _____ State: ____ Zip: _____

Adjuster Name: _____ Adjuster Ph: _____

Claim #: _____ State in which accident occurred: _____

Lawyer Information
Have you retained an attorney? Yes / No If yes, please complete the following information:

Attorney's Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Ph: _____ Fax: _____

Injury Information
Date of Injury: _____ Time of Injury: _____am / pm

Give full description of how accident happened: _____

_____

_____

_____

Vehicle Accident Information
Were you the: □ Driver □ Front Passenger □ Rear Passenger □ Pedestrian

How many people were in the accident vehicle? _____

Make / model of vehicle you were in: _____

Were you wearing a seatbelt? Yes / No What type? _____

Was vehicle equipped with airbags? Yes / No Did they inflate properly? Yes / No

Did your seat have a headrest? Yes / No What was position of headrest? □ Low □ Mid □ High

Accident Site
Name of road / street: _____ City: _____ State: _____

Nearest intersection with road / street: _____

Driving conditions: □ Dry □ Wet □ Icy □ Other: _____

Which direction were you headed? N – S – E – W What speed were you traveling? _____

Impact

Did your car impact another vehicle? Yes / No

Did your car impact a structure? Yes / No If YES, explain _____

Did any part of your body strike anything in the vehicle? Yes / No If YES, explain _____

_____

Was impact from: □ Front □ Rear □ Left □ Right

At the time of impact were you looking: □ Ahead □ Left □ Right □ Up □ Down

Were both hands on the steering wheel? Yes / No If NO, which hand was on the wheel? □ Right □ Left

Was your foot on the brake? Yes / No If YES, which foot was on the brake? □ Right □ Left

Were you: □ Surprised by impact □ Braced for impact

Police

Did the police come to the accident site? Yes / No Were there any witnesses? Yes / No

Was a police report filed? Yes / No Was a traffic violation issued? Yes / No If YES, to whom: _____

Patient Condition

Were you unconscious immediately after the accident? Yes / No If YES, for how long? _____

Please describe how you felt immediately after the accident: _____

_____

_____

Symptoms / Injuries

Have you lost time from work? Yes / No If so, how much time? _____

Prior to the injury were you able to work on an equal basis with others your age? Yes / No

Have you had any of the following symptoms since your injury? (check only those that apply)

□ Arm/shoulder pain	□ Ear ringing	□ Jaw problems	□ Shortness of breath
□ Back pain	□ Fatigue	□ Leg pain	□ Sleep difficulty
□ Back stiffness	□ Feet/toe numbness	□ Memory loss	□ Stomach upset
□ Chest pain	□ Hand/finger numbness	□ Nausea	□ Tension
□ Dizziness	□ Headache	□ Neck pain	□ Vision blurred
□ Ear buzzing	□ Irritability	□ Neck stiffness	

Is this condition getting progressively worse? □ Yes □ No □ Unknown

Treatment

Did you go to the hospital: Yes / No When did you go? □ Immediately □ Next Day □ 2 or more days later

How did you get to the hospital? □ Ambulance □ Private Transportation Name of hospital: _____

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To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient (or Parent/Legal Guardian/ Personal Representative) Date

_____ _____

Print name of Patient (or Parent/Legal Guardian/ Personal Representative) Relationship to Patient