MEDICAL CARE:

If you have not received any medical care since the accident, skip this section and check here (   )

1. Were you seen by paramedics at he accident? (   ) Yes (   ) No
   Did you go to the hospital or doctor following the accident? (   ) Yes (   ) No Name: ____________________
3. How did you get there? (   ) Ambulance (   ) Car
4. Were you examined?(   ) Yes (   ) No Was it thorough? (   ) Yes (   ) No
5. Were you x-rayed? (   ) Yes (   ) No If yes, what areas of your body? ____________________
6. What did the doctors tell you?____________________
7. Did they give you any treatment? (   ) Yes (   ) No If yes, please describe: ____________________
8. Did they give you any medication? (   ) Yes (   ) No ____________________
9. What follow up advice? ____________________
10. Have you been treated by any other doctors since the accident? (   ) Yes (   ) No
    If yes, please list the doctor's name and address: ____________________
    ____
11. Have you received any other medical care up to this point? (   ) Medication (   ) Physical therapy
    Please describe: ____________________
    ____
    ____
    Did it help? ____________________

PAST MEDICAL HISTORY:

1. Did you have any physical complaints BEFORE THE ACCIDENT? (   ) Yes (   ) No If yes, please describe in detail: ____________________
   ____
   ____
2. Do you have any congenital (from birth) factors which relate to this problem?(   )Yes (   )No If yes, please describe:
   ____
   ____
3. Do you have any previous illnesses which relate to this case? (   ) Yes (   ) No
   If yes, please describe: ____________________
   ____
   ____
4. Have you had any other accidents which required medical care? (   ) Yes (   ) No. If yes, please describe, including date(s) and type(s) of accidents, as well as injury(es) received: ____________________
   ____
   ____
   ____

DISABILITY:

1. Have you lost time from work as a result of this accident? (   ) Yes (   ) No
   If yes: Dates of disability: ______________ Type of employment: ____________________
2. Do you notice any activity restrictions as a result of this injury? (   ) Yes (   ) No
   If yes, please describe in detail: ____________________
   ____
   ____

Other pertinent information: ____________________
____
____
____

______________ Date

____________________ Patient's Signature