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ATTORNEY INFORMATION ***ACCIDENT REPORT FOR SPINAL INJURIES***

Name: ________________________________ Phone Number: _______________

Address: _______________________________ ____________________ _________ __________
STREET ADDRESS OR POST OFFICE BOX CITY STATE ZIP CODE

INSURANCE COMPANY INFORMATION

Name: ________________________________ Phone Number: _______________ Claim Number: _____________

Address: _______________________________ ____________________ _________ __________
STREET ADDRESS OR POST OFFICE BOX CITY STATE ZIP CODE

INJURY INFORMATION

Date of Injury: _______________ Time of Injury: ________ ❑ *A.M.* ❑ *P.M.* On-the-Job Injury ❑ *Yes* ❑ *No*

AUTOMOBILE INJURY INFORMATION (FILL OUT THIS SECTION ONLY IF INJURY WAS FROM AUTO ACCIDENT)

Patient's car was going (direction): _______________ Street or Road ____

Closest bisecting street or road (if any): ____________________________________ Town: ______________________

Number of automobiles involved in accident: _______ Number of persons involved in accident: _______

Patient's car was: ❑ *Moving* ❑ *Stopped* ❑ *Turning Left* ❑ *Turning Right*
Car hit/was hit in the: ❑ *Front* ❑ *Rear* ❑ *Left Side* ❑ *Right Side*
Did you see the accident coming? ❑ *Yes* ❑ *No* Were you wearing a seat belt? ❑ *Yes* ❑ *No*
Upon impact - what direction was your body thrown? ❑ Forward ❑ Backward ❑ Left ❑ Right
- was there a "binding" or "explosive" sensation in your head? ❑ Yes ❑ No

Which areas of your body hurt immediately after the accident: ____

____

Were you able to get out of the car and walk? ❑ *Yes* ❑ *No* *Were you* conscious at all times? ❑ *Yes* ❑ *No*

Were you able to move all parts of your body? ❑ *Yes* ❑ *No*

Was a police report made? ❑ *Yes* ❑ *No* Was a citation given? ❑ *Yes* ❑ *No* Citation given to: ❑ Patient ❑ Other(s)

Was an ambulance called? ❑ *Yes* ❑ *No* Did you go to the hospital? ❑ *Yes* ❑ *No*

If so, what was done? ❑ *X-Rays* ❑ *Examination* ❑ Medications (nature): _____________________________________

Length of time in hospital: ____________ Admitted (date): ________________ Released (date): _________________

Were you able to sleep the night of the accident? *Yes* ❑ *No* List discomfort, if any: _____________________________

List discomfort experienced – next day: ____

____

– following day: ____

` ____

– week later: ____

Symptoms Experienced Following Accident/Injury

- ❑ *Eye Complaints*
- ❑ *Ear Complaints*
- ❑ *Facial Disturbances*
- ❑ *Difficulty Swallowing*
- ❑ *Dizziness*
- ❑ Increased Sweating
- ❑ *Nasal Disturbances*
- ❑ *Chest Pain or Disturbances*
- ❑ Burning Muscle Pain
- ❑ *Lapses of Consciousness*
- ❑ *Headaches*
- ❑ *Insomnia*
- ❑ *Restlessness*
- ❑ *Mood Changes*
- ❑ *Behavioral Changes*
- ❑ *Numbness of the Extremities*
- ❑ *Tingling in arms or legs*
- ❑ *Coldness in hands or feet*
- ❑ *Inability to Urinate*
- ❑ *Difficulty Urinating*
- ❑ *Loss of arm or leg strength*
- ❑ *Difficulty moving arms or legs*
- ❑ *Clumsiness*

Please explain any of the above symptoms: ______________________________

____

____

Please list and explain any other symptoms you are experiencing: ______________________

____

____

<u>OTHER INJURY INFORMATION (FILL OUT THIS SECTION ONLY IF INJURY WAS NOT FROM AUTO ACCIDENT)</u>

How did the injury happen? ____

____

____

______________________________ Patient Signature

______________ Date Signed