ADE MEDICAL GROUP

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Today's Date: _____ Date of Accident: _____ State of Accident: _____

Name: _____ Date of birth: _____

Address: _____ City: _____ State: _____ Zip:_____

Phone: _____ Cell: _____ Work: _____

Email: _____

Sex: Male Female **Marital Status**: Married Single **Height**: _____ **Weight**: _____

Insurance Information

Name of **YOUR PERSONAL VEHICLE** Insurance company:
Company: _____
Address: _____
Phone: _____ Adjuster: _____
Claim #: _____ Policy #: _____
Driver of car: _____
Year/Model of car: _____

Other Vehicle Insurance Information:
Company: _____
Address: _____
Phone: _____ Adjuster: _____
Claim #: _____ Policy#: _____
Driver's name: _____
Year/Model of car: _____

Approx damage to your car: $_____
Was anyone ticketed? (circle one) Yes or No You or other driver
Have you retained an Attorney? Yes or No
Name of Attorney: _____ Phone#: _____

Name of YOUR HEALTH MEDICAL Insurance company:
Company: _____ ID: _____

Address: _____ Phone: _____

Policy Subscriber Name: _____ Date of birth: _____

Please describe the accident:

_____

_____

_____

_____

_____

General Information

1. Did you seek immediate attention?
   - o Yes
   - o No (If no, skip to question 4)
2. How did you get there?
   - o Ambulance
   - o Police
   - o Someone else drove me
   - o Drove myself
3. Doctor/Facility Name: _____
   - o Examined
   - o X-rays
   - o MRI
   - o CT Scan
   - o Surgery

   What treatment did you receive?
   - o Brace/Collar
   - o Stitches
   - o Medications
4. Are you currently under any care for injuries related to this accident from any other providers?
   - o Yes (please explain)
   - o No

   _____

   _____
5. Visibility at time of accident:
   - o Poor
   - o Fair
   - o Good
   - o Other

   _____
6. Road Conditions:
   - o Icy
   - o Rainy
   - o Wet
   - o Dry
   - o Other

   _____
7. Type of Accident:
   - o Head-on
   - o Broad side
   - o Front Impact
   - o Rear Impact
8. Where was your car struck?
   - o Front
   - o Rear
   - o Drivers side
   - o Passenger side
9. Does your vehicle have a tow hitch?
   - o Yes
   - o No
10. Did the seatback break?
    - o Yes
    - o No
11. What parts of your body hit what parts of the inside of the car:

    _____

    _____
12. Did you see the accident coming?
    - o Yes
    - o No
13. Did you brace for the impact?
    - o Yes
    - o No
14. Were you wearing a seat belt?
    - o Yes
    - o No
15. Did your seatbelt have a shoulder restraint?
    - o Yes
    - o No
16. Was the position of your headrest even with:
    - o Top of head
    - o Bottom of head
    - o Middle of neck
    - o No headrest
17. At the time of the accident was your car:

    Moving? o Yes o No

    Braking? o Yes o No
18. If moving, what was your approximate speed? _____mph
19. If moving, what was the approximate speed of the other car? _____mph

20. Head/body position at the time of impact:
    - o Head turned left/right
    - o Looking behind you
    - o Head straight ahead
    - o Body straight in sitting position
    - o Body rotated left/right
21. As a result of the accident, were you:
    - o Rendered unconscious
    - o In shock
    - o Dazed
    - o Other
22. Were you wearing a hat or glasses?
    - o Yes
    - o No
23. Could you move all parts of your body?
    - o Yes
    - o No

    If no, what parts couldn't you move and why? _____
24. Were you able to get out of the car and walk unaided?
    - o Yes
    - o No

    If not, why? _____
25. Did you have any cuts that were bleeding?
    - o Yes
    - o No
26. Did you have any bruises?
    - o Yes
    - o No
27. Please describe how you felt: Immediately following the accident:

    _____

    _____

    The next day: _____

28. Check symptoms apparent since the accident:

o Headache	o Neck pain/stiffness	o Mid back pain	o Eyes sensitive to light	o Tension
o Pain behind eyes	o Dizziness	o Fainting	o Loss of smell	o Facial pain
o Loss of taste	o Numbness in fingers/toes	o Sleep problems	o Memory problems	o Irritability
o Fatigue	o Shortness of breath	o Jaw pain/clicking	o Depression	o Constipation
o Loss of balance	o Ears ringing/buzzing	o Anxiety/nervous	o Lower back pain	o Diarrhea
o Loss of Focus/attention	o Difficulty completing tasks	o Other _____		

29. Do you work:
    - o Full time
    - o Part time
    - o Not currently working prior to accident
30. Occupation: _____
31. Employer: _____
32. Have you missed time from work?
    - o Yes
    - o No
33. Dates you were unable to work: _____ to _____
34. Have you been unable to do housework?
    - o Yes
    - o No

    If not, dates unable to do housework: _____ to _____
35. Do you have any pictures of the event?
    - o Yes
    - o No

    If so, pictures of what?
    - o Car
    - o Self
    - o Other_____

Use the space below to add any additional information.