PATIENT FULL NAME: _____ DATE: _____

ADDRESS: _____

PHONE: _____ Email: _____

GENDER: _____ HEIGHT: _____ WEIGHT: _____ DATE OF BIRTH: _____ AGE: _____

LEFT OR RIGHT - HANDED: _____ DATE OF ACCIDENT/DOL: _____

ATTORNEY OR CASE MANAGER NAME: _____ PHONE: _____

ATTORNEY/LAW FIRM NAME: _____FAX: _____

ATTORNEY/LAW FIRM ADDRESS: _____

PLEASE PROVIDE AS MUCH INFORMATION AS POSSIBLE so your case can be set up properly. In the State of Arizona, insurance laws read that you have the right to bill any insurance policy under which you have coverage. In the case of more than one insurance coverage, overpayment may occur. We only need to be paid once so all the overpayments will be reimbursed to you at the time you are released from care. Please initial if you understand this language. _____ (Initials) Please speak to our office staff if you need further clarification, thank you!

PRIMARY INSURANCE (Health Insurance Coverage You Have):

Insured's Name: _____ Carrier: _____

ID #: _____ Group #: _____ Phone: _____

MED PAY COVERAGE (INSURANCE COVERAGE CARRIED ON THE AUTO INSURANCE POLICY OF THE CAR YOU WERE IN

WHEN IN THE ACCIDENT) This coverage is for any injuries that may have occurred to any person in that automobile. It will cover anything from an automobile accident that either was or was not your fault. Using this portion of the auto policy CANNOT RAISE YOUR PREMIUMS. In fact, this is exactly why "MED PAY" coverage is paid for on an auto insurance policy – to pay medical bills resulting from an accident. Please initial if you understand this language. _____ (Initials) Please speak to our office staff if you need further clarification, thank you!

Policy Holder (Owner of the Automobile Holding the Med Pay Coverage) _____

Insurance Company: _____ Phone #: _____

Policy #: _____ Claim #: _____

Adjuster: _____ Phone: _____

Adjuster Address: _____

THIRD PARTY LIABILITY INSURANCE (Insurance for the Person who was driving the "other car")

Other Driver's Name: _____ Policy Holder's Name: _____

Insurance Company: _____ Phone: _____

Policy #: _____ Claim #: _____

Adjuster: _____ Phone: _____

Adjuster Address: _____

For this incident, did you lose consciousness? Yes _____ No _____ Not sure _____

For this incident, did you go to a hospital? Yes immediately _____ Yes later _____ No____

For this incident, who was the first doctor you saw:

Doctor's Name: _____ Doctor's phone: _____

For this incident, name any other doctor you have seen:

Doctor's Name: _____ Doctor's phone: _____

Doctor's Name: _____ Doctor's phone: _____

For this incident, have you had any treatment from a chiropractor: Yes_____ No _____

Chiropractor's Name: _____ Chiropractor's phone: _____

For this incident, have you had any treatment from a physical therapist: Yes_____ No _____

Therapist's Name: _____ Therapist's phone: _____

Has any healthcare provider ever diagnosed you as having had a concussion prior to this incident? YES ____ NO _____

If yes, in the past 12 months, were you seeking any medical advice or any treatment for that prior concussion?

YES _____ NO _____ IF YES, PLEASE FULLY DESCRIBE:

_____

_____

HAVE YOU TAKEN ANY MEDICATIONS IN THE LAST 72 HOURS? YES _____ NO _____

IF YES, WHAT DID YOU TAKE? _____

HAVE YOU HAD ANY ALCOHOL IN THE LAST 72 HOURS? YES _____ NO _____

IF YES: HOW MUCH? _____

HAVE YOU HAD ANY FORM OF MARIJUANA IN THE LAST 72 HOURS? YES _____ NO _____

HAVE YOU EATEN A BIG MEAL IN THE LAST 2 HOURS? YES_____ NO _____

HAVE YOU HAD CAFFEINE IN THE LAST 4 HOURS? YES_____ NO _____

TYPE OF ACCIDENT: (circle) DRIVER PASSENGER PEDESTRIAN WORK OTHER: _____

WHO HIT WHO OR WHAT? (circle) Your vehicle hit the other vehicle The other vehicle hit your vehicle.

OTHER (explain): _____

WERE THE POLICE ON SCENE? YES_____ NO ___

WAS A POLICE REPORT FILED? YES_____ NO _____

WAS ANYONE TICKETED? YES_____ NO _____ IF YES, WHO _____

VEHICLE: (circle) CAR SUV PICKUP TRUCK LARGE TRUCK BUS STATION WAGON OTHER: _____

WERE YOU STRUCK FROM: (circle) BEHIND FRONT DRIVER SIDE PASSENGER SIDE

WHAT WAS THE CAR DOING AT TIME OF ACCIDENT? (circle) Stopped at Intersection Slowing Down

Proceeding Along Stopped at Light Stopped in Traffic Parking Accelerating

Other: _____

Your Vehicles Speed: _____ Other Vehicles Speed: _____

ROAD CONDITIONS AT TIME OF ACCIDENT: (circle) ICY WET SANDY DARK CLEAN & DRY

VISIBILITY AT TIME OF ACCIDENT: (circle) Poor Fair Good

WHERE DID THE ACCIDENT OCCUR? _____

NUMBER OF PEOPLE IN YOUR VEHICLE? Yours _____

WHAT DIRECTION WERE YOU HEADED? _____

WHAT DIRECTION WAS THE OTHER VEHICLE WAS HEADED? _____

DESCRIBE YOUR INJURIES: _____

_____

DESCRIBE THE INCIDENT: _____

_____

DID YOU SEE THE ACCIDENT COMING? YES_____ NO _____

WERE YOU BRACED FOR IMPACT? YES_____ NO _____

DID YOU HAVE A SEATBELT ON? YES_____ NO _____

DID YOU HAVE A SHOULDER HARNESS ON? YES_____ NO _____

DID THE AIRBAGS DEPLOY? YES_____ NO _____

DID THE VEHICLE HAVE HEAD RESTS? YES_____ NO _____

DID YOUR HEAD STRIKE THE INSIDE OF THE VEHICLE? YES_____ NO _____ IF YES, DESCRIBE:

_____

DID YOU LOSE CONSCIOUSNESS? YES_____ NO _____ IF YES, HOW LONG?

_____

WHERE DID YOU GO AFTER THE ACCIDENT? (circle) HOME WORK HOSPITAL PRIVATE DOCTOR

HOW DID YOU GET THERE? (circle) DROVE SELF SOMEONE ELSE AMBULANCE POLICE

MRI OR CT DONE? YES_____ NO _____ IF YES, WHERE? _____

BODY PART? _____

LAB WORK? YES_____ NO _____ IF YES, WHERE? _____

PREVIOUS ACCIDENTS

Have you been in Accidents Prior to this? YES_____ NO _____ If Yes, When _____

Did you receive medical treatments? YES_____ NO _____

SUBJECTIVE COMPLAINTS

Have you developed any of the following symptoms or complaints at any time since this incident?

I = Initially, within 72 hours of the incident C = Currently, today N = Never

Anxiety I ___ C ___ N ___ Back Pain I ___ C ___ N ___ Balance Problems I ___ C ___ N ___

Blurred Vision I ___ C ___ N ___ Confusion I ___ C ___ N ___ Depression I ___ C ___ N ___

Difficulty Breathing I ___ C ___ N ___ Difficulty Multi-Tasking I ___ C ___ N ___ Delusions I ___ C ___ N ___

Difficulty Carrying on Conversations/Tasks I ___ C ___ N ___ Dizziness I ___ C ___ N ___ Ears Ringing I ___ C ___ N ___

Facial Muscle Weakness I ___ C ___ N ___ Fainting I ___ C ___ N ___ Fatigue I ___ C ___ N ___

Headache I ___ C ___ N ___ Hearing Loss I ___ C ___ N ___ Impulsiveness I ___ C ___ N ___

Loss of Smell I ___ C ___ N ___ Loss of Taste I ___ C ___ N ___ Memory Problems I ___ C ___ N ___

Mood Swings I ___ C ___ N ___ Nausea I ___ C ___ N ___ Neck Pain I ___ C ___ N ___ Neck Stiffness I ___ C ___ N ___

Nervousness I ___ C ___ N ___ Neurological Issues I ___ C ___ N ___ Nightmares I ___ C ___ N ___

Pain Behind Eyes I ___ C ___ N ___ Panic Attacks I ___ C ___ N ___ Poor Appetite I ___ C ___ N ___

Poor Concentration I ___ C ___ N ___ Restlessness I ___ C ___ N ___ Sensitivity to Light I ___ C ___ N ___

Sensitivity to Sound I ___ C ___ N ___ Sleep Problems I ___ C ___ N ___ Word Finding Issues I ___ C ___ N ___