PERSONAL INJURY INTRODUCTION FORM

Full Legal Name	Today's Date

AUTOMOBILE INSURANCE INFORMATION

Do you or someone else have insurance coverage for the vehicle you were in? ☐ I have, ☐ Someone else Who's the name of the person that the policy is under:
How is the insured person related to you? ☐ Self, ☐ Parent, ☐ Friend, ☐ Other
Was **YOUR** insurance active and up to date at the time of the accident? ☐ Yes, ☐ No

YOUR INSURANCE (✳✳✳Complete regardless of who's at fault✳✳✳)

Name of **YOUR** Automobile Insurance Carrier:	Carrier Name	
Address of **YOUR** Automobile Insurance Carrier:	Street Address:	
	City, State, Zip:	
YOUR Claim Adjusters Name/Telephone Number:	Name:	
	Telephone :	
Policy Number:		**Claim Number**:
Have you reported this injury to your insurance carrier? ☐ Yes, ☐ No		Do you have medical payments coverage on your auto policy? ☐ Yes, ☐ No

ATTORNEY

☐ Yes, ☐ No. Do you have an attorney representing you?	Telephone:
Law Office:	
Attorney Name:	Paralegal/Legal Assistant:
Street Address:	City, State, Zip:

THIRD PARTY

Name of **THEIR** Automobile Insurance Carrier:	Carrier Name	
Address of **THEIR** Automobile Insurance Carrier:	Street Address:	
	City, State, Zip:	
THEIR Claim Adjusters Name/Telephone Number:	Name:	Telephone :
Policy Number:		**Claim Number:**

I am ultimately responsible for all charges that are incurred at the doctor's office. I agree to pay for any outstanding bills incurred in this office, as well as paying for co-insurance or deductibles.	Signature and Date:

Full Legal Name

POST-TRAUMATIC SYMPTOM QUESTIONNAIRE

PATIENT INSTRUCTIONS: It is important for this section to be filled out in detail. Look at each symptom listed in the left column and make a single check mark or several check marks in the appropriate columns for the specific symptom which applies to you. Be certain to indicate when you had the beginning of any of the following symptoms. Leave the row blank if the symptom listed below does not apply to you.

SYMPTOM LIST (Check all that apply to you)	BEGAN IN LESS THAN 24 HOURS AFTER INJURY	BEGAN 1 TO 7 DAYS AFTER INJURY	YOU HAVE SYMPTOMS PRESENTLY	HAD SIMILAR SYMPTOMS WITHIN 12-MONTHS PRIOR TO THE INJURY
Headache/migraine				
Dizziness				
Tinnitus (ear ringing)				
Blurry vision				
Memory problems				
Poor concentration				
Nausea or vomiting				
Balance problems				
Loss of coordination				
Sensitivity to sound				
Sensitivity to light				
Fatigue				
Loss of smell				
Pain/difficulty swallowing				
Jaw pain/soreness				
Neck pain/soreness/aching/stiff				
Shoulder pain/stiffness				
Arm pain/tingling/numbness				
Wrist/hand/finger pain/numbness				
Weakness in arms/legs				
Upper/middle back pain/soreness				
Chest pain or bruising				
Rib cage pain or bruising				
Abdominal-Pelvic pain or bruising				
Low back pain/soreness/aching				
Hip pain or bruising				
Upper leg or thigh pain				
Leg numbness/tingling				
Pain radiating down leg(s)				
Lower leg or calf pain				
Knee pain				
Ankle/foot/toe pain				
Other:				
Other:				