Spine & Sport Rehabilitation

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www.kcspineandsport.com

Patient Information

Date: _____ / _____ / _____

Name: ___________________________________

Date of Birth: _____ / _____ / _____

Accident Information

Date Of Accident: _____ / _____ / _____

Time Of Accident: ________ AM PM

What state did the accident occur in? __________

Please explain in detail how your accident happened?

____

____

____

Which direction were you heading?

North South East West

Number of people in the car? _____________

Were the police notified? Yes No

Did your head strike any object? Yes No

Were you knocked unconscious? Yes No

If yes, for how long? _____________

Where were you struck?

Behind Front Left Side Right Side

You were?

Driver Passenger- Front Passenger- Back

Were you wearing your seat belt? Yes No

Other Driver's Insurance Information

Insurance Company: _______________________

Address: _________________________________

City: _____________ State: _____ Zip: _______

Policy No.: ______________________________

Claim No.: ______________________________

Adjustor Name: ___________________________

Adjustor Phone Number: ____________________

Your Auto Insurance Information

Insurance Company: _______________________

Address: _________________________________

City: _____________ State: _____ Zip: _______

Policy No.: ______________________________

Claim No.: ______________________________

Adjustor Name: ___________________________

Adjustor Phone Number: ____________________

Have you retained an attorney?

Yes No Not Yet

If yes, please answer the following:

Name: ___________________________________

Address: _________________________________

City: _____________ State: _____ Zip: _______

Phone Number: ____________________________

Medical Information

When did you feel pain after the accident?

Immediately Later That Day Next Day

Where did you feel pain after the accident?

____

Where were you taken after the accident?

____

Was any doctor consulted after the accident occurred? Yes No

If yes, please provide the following:

Name: _________________________

Phone: _________________________

Doctor's Diagnosis:

____

Was any treatment given? What type?

____

How often and long did you see this doctor?

____

Have you ever had any complaints in the involved area before? Yes No

If yes, what were the complaints?

____

Before the injury, were you capable of working on an equal basis with others your age?

Yes No

Are your work activities restricted now?

Yes No

Since the injury, are your symptoms:

Improving Getting Worse The Same