GOODMAN CAMPBELL
BRAIN AND SPINE

ACCIDENT INFORMATION

Name: Date of Birth:

IS THIS VISIT THE RESULT OF AN ACCIDENT? ☐YES ☐NO
If yes, please continue filling out this form.

Nature of Accident:

☐Car accident ☐Fall ☐Sporting accident ☐Assault (a fight or beating) ☐Gunshot ☐Other: _____

Where were you injured?

☐In my own home

☐At work

Is this a worker's comp injury? ☐Yes ☐No
Date of injury: _____
Your employer's worker's comp carrier name:_____
Address of carrier: _____ Phone: _____
City/State: _____ Zip: _____ Claim #: _____
Case manager name: _____ Phone: _____ Fax: _____

☐In a motor vehicle accident

Date of accident: _____ Location of accident: _____
Have you contacted the other driver's car insurance company? ☐Yes ☐No

☐At a business

Date of accident: _____ Have you filed an insurance claim? ☐Yes ☐No
What is the name of the business? _____
What is the owner's name? _____ Phone: _____
What is the address of the business? _____

☐At someone's house

Date of accident: _____ Have you filed a homeowner's insurance claim? ☐Yes ☐No
What is the name of the person that owns the home? _____
What is the address? _____

☐Other

Regardless of the cause of the accident, please complete the questions below:

Is there litigation pending (suing in a court of law)? ☐Yes ☐No
Are you considering litigation (suing)? ☐Yes ☐No
If yes to either question, what is the name and phone number of your attorney?_____
_____

Please describe the accident: _____

_____

_____

_____

_____

_____

Had you ever experienced your symptoms before the accident? ☐Yes ☐No

If the accident was due to a fall, how did you fall? _____

If this was a bicycle, motorcycle or ATV accident, were you wearing a helmet? ☐Yes ☐No ☐N/A

If this was a car accident, did you have your seat belt on? ☐Yes ☐No ☐N/A

Did you have a shoulder strap on? ☐Yes ☐No

Did the air bag deploy or go off? ☐Yes ☐No

How fast was your car driving? _____

How fast was the car that hit you driving? _____

Where were you sitting in the car?

☐Driver's seat ☐Front passenger seat ☐Back seat, driver's side

☐Back seat, passenger side ☐Other: _____

When did you first seek medical treatment? _____ Where? _____

What tests were done? _____

What was your diagnosis? _____ Who was your doctor? _____

Were you taken to a hospital by ambulance? ☐Yes ☐No

If you were in the hospital, for how long? _____ Hospital name: _____

Doctor's name: _____

What kind of work do you do? _____

What was the last day you worked? _____

Please list anything else you would like your doctor to know about the accident and its effects on you:

_____

_____

_____

_____

_____