FOREVER YOUNG HEALTH & WELLNESS LLC **Automobile Accident Form** **Today's Date_____/_____/_____**

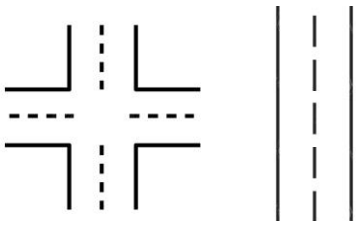
Your Information	**Information of Other Vehicle Involved**
Name_____	
Date and Time of Accident___/___/_____	Name of Person_____
Your Auto Insurance_____	Auto Insurance_____
Claim Number_____	Claim Number_____
Adjusters Name_____	Adjusters Name_____
Insurance Address _____	Insurance Address _____
_____	_____
Insurance Phone Number _____	Insurance Phone Number _____
Year, Make and Model of your car?_____	Year, Make and Model of other car?_____
_____	_____

Did you seek medical help immediately/soon after the accident? □ Yes □ No
If yes, who did you first get treatment from? DOCTOR / HOSPITAL / CLINIC:
_____
Date of first visit: _____
Were you taken by ambulance? □ Yes □ No
Were you examined? □ Yes □ No
Were x-rays taken? □ Yes □ No
Did you receive treatment? □ Yes □ No
Did the treatment help? □ Yes □ No How?_____

If yes, what treatment did you receive? _____

INDICATE ON THESE DRAWING WHAT HAPPENED

1. Write street or highway names and numbers
2. Label your vehicle
3. Use line to show path of accident
4. Indicate north by an arrow ↑ N



Please explain what happened to your car during the accident_____
_____
_____
_____

Where were you seated? □ Driver □ Front passenger □ Rear passenger side □ Rear middle □ Rear driver side
Were you struck from: □ Behind □ Front □ Left side □ Right side □ Other _____
Were you aware of the collision prior to impact? □ Y □ N
Did you brace for impact? □ Y □ N
Was your head: □ Pointed straight forward □ Turned to the left □ Turn to the right □ Looking down □ Looking up
Were you wearing a: □ seatbelt □ seatbelt with shoulder harness □ none
Does your car have airbags? □ Y □ N Did they deploy? □ Y □ N
Was you head rest: □ adjusted properly □ adjusted high □ adjusted low
Impact felt: □ Mild □ Moderate □ Severe

Was the weather: □ Sunny □ Clear □ Overcast □ Raining □ Snowing
Was the road: □ Dry □ Wet □ Slushy □ Icy □ Snow packed
Was visibility: □ Good □ Poor
Was your car moving at the time of the accident? □ Y □ N If yes, how fast _____
Were you braking? □ Y □ N **Did you/driver push on the brake throughout the collision?** □ Y □ N
Was the other car moving at the time of the accident? □ Y □ N If yes, how fast _____

What happen to you upon impact_____
_____

What parts of you head and/or body were hit/injured inside the car during the accident?
_____
_____

Did you lose consciousness (black out)? □ Y □ N If yes, how long?
Were you dazed/confused? □ Y □ N
Did you receive bleeding cuts? □ Y □ N Where?_____
Did you receive bruises? □ Y □ N Where?_____
Describe how you felt:

a) Immediately after the accident_____
_____
b) Later that day _____
c) The next __ day(s)_____

Check the symptoms you have noticed since the accident:

□ Headaches	□ Loss of balance	□ Sleeping problems	□ Diarrhea
□ Neck pain	□ Loss of smell	□ Numbness in toes	□ Constipation
□ Mid back pain	□ Loss of memory	□ Numbness in fingers	□ Stomach upset/pain
□ Low back pain	□ Fatigue	□ Pins & needles in arms	□ Blood in urine
□ Shoulder pain	□ Tension	□ Pins & needles in legs	□ Chest pain
□ Elbow pain	□ Shortness of breath	□ Cold hands	□ Nervousness/anxiety
□ Wrist pain	□ Irritability	□ Cold feet	□ Depression
□ Hand pain	□ Dizziness	□ Cold sweats	□ Fainting
□ Hip pain	□ Eyes sensitive to light	□ Head feels to heavy	□ Difficulty swallowing
□ Knee pain	□ Ankle/foot pain	□ Ringing/buzzing in ears	□ Other _____

Since the accident are your symptoms □ Improving □ Getting worse □ About the same

WORK

Have you missed time from work? □ Yes □ No

If Yes, How much time have you missed? _____

Are you working while in pain? □ Yes □ No

List work activities that you are now **unable** to do _____

List work activities that are **painful** to do _____

List work activities that are now **difficult** to do _____

DAILY ACTIVITIES (BE SPECIFIC)

List daily activities that you are now **unable** to do _____

List daily activities that are **painful** to do _____

List daily activities that are now **difficult** to do _____

Patient or patient guardian signature: _____