PATIENT ACCIDENT FORM

Name _____ Date _____ Date of Accident_____

Vehicles Involved:

Your vehicle: Year _____ Make_____ Model _____

Other vehicle: Year_____ Make_____ Model_____

Accident type:

◯ Rear-ended ◯ Head-on ◯ Broad-sided Your speed_____ Other vehicle speed _____

Damage to your vehicle: $ _____ Damage to other vehicle: $_____

Describe: _____

_____

_____

_____

Specifics of accident (Mark each that applies to the accident job or work related injury)

You were sitting:	◯ Driver	◯ Passenger	Immediately Following the Accident:
	◯ Front Seat	◯ Back Seat	◯ Ambulance - paramedics called
	◯ Seat Belted	◯ No Seatbelt	◯ Treated at Scene
Impending Collision	◯ Aware	◯ Unaware	◯ Taken by ambulance to hospital
	◯ Braced	◯ Not Braced	◯ Went to hospital on their Own
Head Did____	◯ Strike Object	◯ Not Strike Object	◯ Diagnostics done at Hospital
	◯ Break Glass	◯ Airbag deployed	◯ Treatment at Hospital
Did you experience	◯ Shock Loss of Consciousness		◯ Medication Prescribed
	◯ Flash of Light seen upon impact		◯ Follow-up recommended

State your emotions and physical state immediately following the accident:

_____

_____

_____

State your emotions and physical state after the first few days:

_____

_____

_____

Other doctors seen:

◯ Orthopedist
◯ Neurologist
◯ Psychiatrist
◯ Physical Therapist
◯ Massage Therapist
◯ Chiropractor
◯ Other: _____

The road was:	The weather conditions were:		Time of Day:
◯ Dry	◯ Sunny	◯ Light Rain	◯ Dawn
◯ Wet	◯ Cloudy	◯ Heavy Rain	◯ Day
◯ Icy	◯ Foggy	◯ Snowing	◯ Dusk
◯ Snowy	◯ Sleeting	◯ Hailing	◯ Night

Symptomatology: (pain characteristics for major area of complaint)

The pain started: _____

The pain is made better by: _____

The pain is made worse by: _____

The pain has the following qualities: _____

◯ There is ◯ There is not radiation into _____

◯ There is ◯ There is not referred pain into _____

◯ There is ◯ There is not paresthesia (tingling/numbness) into _____

The pain is located _____

The pain is ◯ frequent ◯ constant ◯ occasional ◯ comes and goes ◯ other _____

Daily Activities

How many days out of the week do you have pain? _____

How much time in an average day are you in pain? _____

What are the worst times of day for the pain? _____

What are the best times of day for the pain? _____

What do you do to relieve the pain? _____

How do the following activities affect your pain?

	No Change	Relieves Pain	Increases Pain	Duration
Sitting	◯	◯	◯	_____
Walking	◯	◯	◯	_____
Standing	◯	◯	◯	_____
Lying Down	◯	◯	◯	_____
Looking Up	◯	◯	◯	_____
Looking Down	◯	◯	◯	_____
Lifting	◯	◯	◯	_____

Describe the overall severity of the pain:

◯ A mild nuisance ◯ Mild to moderate but can live with it

◯ Moderate, having trouble coping with it ◯ Severe, it is ruining my quality of life

How is your pain compared to when it first started?

◯ Much improved ◯ Somewhat improved ◯ No change ◯ A little worse ◯ Much Worse

Pain Rating

No Pain *Severe Pain*

1 2 3 4 5 6 7 8 9 10

Please mark each that apply to your daily activities due to the problem:

◯ Have to sit most of the day

◯ Stay in bed most of the day

◯ Can only walk short distances

◯ Walk more slowly than usual

◯ Have to lie down and rest frequently

◯ Can only stand for short periods

◯ Have difficulty bending or kneeling

◯ Have difficulty turning over in bed

◯ Have to hold onto something to sit or stand from a chair

◯ Stay at home most of the time

◯ Cannot do jobs around the house

◯ Have a loss of appetite

◯ Have difficulty sleeping

◯ Am more irritable

◯ Have to get other people to do things for me

◯ Have difficulty or need help getting dressed

◯ Change positions frequently to get comfortable

◯ Have to use handrails to get up and down stairs, etc.

How often do you have to stop activities to sit or lie down to control your symptoms:

◯ Several times daily ◯ Occasionally ◯ Approximately once daily ◯ Never ◯ All day

What hobbies and activities are you actively participating in? _____

_____

Are there recreational activities you participated in before this current problem that cannot be performed to the same extent as before? _____

_____

Please mark any below that apply to you:

◯ Single

◯ Married

◯ Divorced

◯ Children: how many in your household _____

◯ Smoker

◯ Non-smoker

◯ Drinks alcohol

◯ Does not drink alcohol

◯ Uses illegal drugs

◯ Uses prescription opiates

Have you seen any other physicians or practitioners for this problem? ◯ Yes ◯ No If yes, list below:

_____

What diagnostic testing have you had following the accident?

◯ X-Ray
◯ CT scan
◯ MRI
◯ EMG
◯ Other: _____

Which of the following treatments have you done since the accident, if any?

◯ Hot Packs
◯ Ultrasounds
◯ Electrical Stimulation
◯ TENS unit
◯ Stretching exercises
◯ Strengthening exercises
◯ PT
◯ Inversion or Traction
◯ Bed Rest
◯ Chiropractic
◯ Acupuncture
◯ Osteopathy
◯ Biofeedback
◯ Trigger Point Injections
◯ Epidural Injections
◯ Back Brace
◯ Naturopathy
◯ Other: _____

List your past surgeries: _____

_____

_____

List your past hospitalizations: _____

_____

_____

List previous back, neck, and musculoskeletal problems: _____

_____

_____

List your current medications: _____

_____

_____

Occupational History:

Your employer _____ Job Title _____

Are your job duties physically demanding for you? ◯ Yes ◯ No

Have you had any disability time? ◯ Yes ◯ No

If you are currently working, which are you performing? ◯ Regular duties ◯ Limited - Light Duties

What is your current job satisfaction? ◯ Very satisfied ◯ Satisfied ◯ Dissatisfied ◯ Very Dissatisfied

What is your highest level of education attained? _____

Medical Report and Doctor's Lien

I do hereby authorize Dr. Steven C. Mangas and Dr. Chloe Tillman at 6699 Rockville rd. Indianapolis, IN 46214 to furnish my attorney with a full report of their examination, diagnosis, treatment, prognosis, etc., in regard to the accident suffered.

I hereby authorize and direct my attorney to pay directly to said doctor or make lien against such sums as may be due and owed them for services rendered by reason of this accident and by reason of any other bills that are outstanding and to withhold such sums from any settlement, judgement, or verdict as may be necessary to adequately protect said doctor.

I agree never to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney will honor this lien as inherent to the settlement - and enforceable upon the case as if it were executed by him.

I fully understand that I am directly and fully responsible to said doctor for all medical and chiropractic bills submitted by them for services rendered and that payment is not contingent on settlement, judgement, or verdict. I understand that if no settlement, judgement, or verdict occurs within one month after Dr. Steven C. Mangas or Dr. Chloe Tillman releases me as a patient, or if I discontinue care against Dr. Mangas's or Dr. Tillman's advice, that I will personally pay Dr. Mangas or Dr. Tillman on demand the monies owed them for services rendered. I understand that if collection procedures are required that I will be held responsible and that if a monthly payment schedule is necessary, a carrying charge may be applied.

I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but will require me to make payments on a time and current basis in manner agreeable to said doctor.

The agreement is made solely for said doctor's additional protection and in consideration for their waiting.

I have read and fully understand the above agreement.

Patient's signature: _____ Date: _____

The undersigned being attorney of record for the above patient does hereby agree to observe all terms of the above and agrees to withhold such sums from any settlement, judgement, or verdict, as may be necessary to protect said doctor above-named.

Attorney's signature: _____ Date: _____

Billing Information for Personal Injury

Name of Insurance Company _____

Insurance Company Claims Address _____

City _____ State _____ ZIP _____

Insurance Contact _____

Ins. Contact Phone _____ Email _____

Claim Number: _____ Name of Policy Holder: _____