

Were you injured in any previous accidents? \_\_\_\_\_ Did you receive treatment for those injuries? \_\_\_\_\_  
 Medical    Orthopedic    Chiropractic    Physical therapy  
 Massage    Acupuncture

Please indicate the symptoms that are A RESULT OF THIS ACCIDENT with an "X"

Please indicate any symptoms you had BEFORE THIS ACCIDENT by circling them

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Headaches          | <input type="checkbox"/> Blurred vision |
| <input type="checkbox"/> Ringing/buzzing in ear | <input type="checkbox"/> Neck pain          | <input type="checkbox"/> Jaw problems   |
| <input type="checkbox"/> Arms/shoulder pain     | <input type="checkbox"/> Numb hands/arms    | <input type="checkbox"/> Back pain      |
| <input type="checkbox"/> Low back/hip pain      | <input type="checkbox"/> Leg pain/ sciatica | <input type="checkbox"/> Leg numbness   |

Is your condition getting worse?    YES    NO    Constant    Comes and goes

Have you retained an attorney?    YES    NO   If yes, whom: \_\_\_\_\_  
His/her phone #: \_\_\_\_\_

Please use the diagram below to demonstrate what happened in the accident.  
Designate the car you were in as #1 and the other car as #2. Any others as #3.....

