



NORTHWESTERN
HEALTH SCIENCES
UNIVERSITY

AUTO INJURY INFORMATION

Name _____ Date: _____

AUTO ACCIDENT INFORMATION:

Accident Date _____ Was a Police or State Patrol report made? Yes / No

Accident Location _____

Were you the Driver ____ Passenger ____

Were you injured? Yes / No Describe your injury: _____

Were you taken to a hospital? Yes / No List the Hospital Name _____

Were you hospitalized? Yes / No Name of Hospital and Dr. _____

What are your present complaints? _____

What treatments have you received to this point? _____

Was there anyone else in the accident with you? Yes / No If yes, who? _____

OTHER DOCTORS SEEN FOR THIS CONDITION:

Doctor's name _____ Phone _____

Address _____

Treatment: Medication(s) _____

Did you miss any time from work? Yes / No If yes, how much? _____

Have you returned to the same job? Yes / No If not, why? _____

Are you represented by an attorney: Yes / No

Attorney's name _____ Phone _____

Address _____

Insurance Company _____ Claim number _____

Address _____ Policy number _____

Adjuster's phone # _____