FOUNTAIN VALLEY

PHYSICAL MEDICINE

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FOUNTAIN VALLEY PHYSICAL MEDICINE AUTOMOBILE ACCIDENT HISTORY FORM

YOUR NAME:_____ TODAY'S DATE:_____

DATE OF ACCIDENT:_____TIME OF ACCIDENT:_____AM PM

CITY OF ACCIDENT:_____STREET OF ACCIDENT:_____

ROAD CONDITIONS AT TIME OF ACCIDENT: WET DRY ICY OTHER_____

DID THE POLICE COME TO THE ACCIDENT SCENE? _____ IS THERE A REPORT?_____

DID YOU GOT TO A HOSPITAL?_____ SAME DAY? _____ NEXT DAY?_____

IF YES, NAME AND CITY OF HOSPITAL?_____

HOW DID YOU GET TO THE HOSPITAL?_____

WHAT PARTS OF YOUR BODY WERE X-RAYED AT THE HOSPITAL?_____

WHAT DID THE HOSPITAL DO FOR YOUR INJURIES?_____

_____

HOW LONG DID YOU STAY AT THE HOSPITAL?_____

HAVE YOU SEEN ANY OTHER DOCTOR AS A RESULT OF THIS ACCIDENT?_____

DOCTOR'S NAME_____

WHAT BLEEDING CUTS OR BRUISES DID YOU SUSTAIN DURING THIS ACCIDENT?_____

WHERE WERE YOU SEATED IN THE VEHICLE?_____

WERE YOU AWARE OF THE APPROACHING COLLISION PRIOR TO IMPACT, OR DID IMPACT CATCH YOU BY SURPRISE? (PLEASE CIRCLE) AWARE SURPRISE

DID YOU LOSE CONSCIOUSNESS (BLACK OUT) UPON IMPACT?_____HOW LONG_____

AFTER IMPACT, DID YOU BECOME (PLEASE CIRCLE):

CONFUSED DISORIENTED LIGHTHEADED DIZZY NAUSEATED BLURRED VISION RING/BUZZ IN EARS

IF YOU STILL HAVE ANY OF THOSE SYMPTOMS, WHICH ONES?_____

ARE YOU CURRENTLY SUFFERING FROM ANY OF THE FOLLOWING (PLEASE CIRCLE):

RESTLESSNESS IRRITABLE DIFFICULTY WITH MEMORY FORGETFULNESS
DIFFICULT CONCENTRATING SLEEPLESSNESS REDUCED TOLERANCE TO HEAT

HOW FAR IS THE TOP OF THE HEADREST OR SEATBACK FROM THE TOP OF YOUR HEAD (APPROXIMATELY)?_____ INCHES ABOVE OR BELOW

WERE YOU WEARING A SEATBELT? YES NO

IF YES, WAS IT A LAP SEATBELT?_____ OR A SHOULDER-LAP SEATBELT?_____

LIST THE FOLLOW INFORMATION FOR THE VEHICLE YOU WERE IN:

YEAR_____ MAKE_____ MODEL_____

WAS YOUR CAR STOPPED AT THE TIME OF IMPACT? YES NO

IF YES, WAS THE DRIVER'S FOOT ON THE BRAKE? YES NO

IN NO, THEN ESTIMATE THE SPEED OF THE VEHICLE YOU WERE IN:_____MILES PER HOUR.

IF YOUR VEHICLE WAS MOVING AT THE TIME OF IMPACT, WAS IT (PLEASE CIRCLE):

SLOWING DOWN GAINING SPEED TRAVELING AT A STEADY RATE OF SPEED

ON WHAT PART OF THE AUTOMOBILE DID YOUR FOLLOWING BODY PARTS HIT?

HEAD HIT_____
CHEST HIT_____
RIGHT/LEFT SHOULDER HIT_____
RIGHT/LEFT ARM HIT_____
RIGHT/LEFT HIP HIT_____
RIGHT/LEFT LEG HIT_____
RIGHT/LEFT KNEE HIT_____
OTHER_____

DID YOU RECEIVE ANY INJURY FROM THE SEAT BELT? YES NO

IF YES, PLEASE DESCRIBE:_____

WHAT IS THE ESTIMATED COST OF DAMAGE TO THE VEHICLE YOU WERE IN? $_____

WHICH OF THE FOLLOWING CAR PARTS BROKE DURING THE ACCIDENT? (PLEASE CIRCLE)

WINDSHIELD FRONT SEAT BACK RIGHT/LEFT SIDE WINDOW STEERING WHEEL
OTHER_____

WAS THE TRUNK OF YOUR BODY POINTED STRAIGHT FORWARD AT THE TIME OF THE COLLISION? YES NO

IF NO, HOW WAS IT TURNED? _____

WAS YOUR HEAD POINTED STRAIGHT FORWARD? YES NO

IF NO, WHAT DIRECTION WAS IT TURNED AND BY HOW MUCH? _____

WHAT WAS THE YEAR, MAKE AND MODEL OF THE OTHER VEHICLE?

YEAR _____ MAKE _____ MODEL _____

WAS THE OTHER VEHICLE MOVING AT THE TIME OF THE COLLISION? YES NO

IF YES, WHAT WAS ITS APPROXIMATE SPEED? _____ MILES PER HOUR.

IF THE OTHER VEHICLE WAS MOVING AT THE TIME OF THE COLLISION, WAS IT (PLEASE CIRCLE):

SLOWING DOWN GAINING SPEED TRAVELING AT A STEADY SPEED

PLEASE DESCRIBE, TO THE BEST OF YOUR KNOWLEDGE, WHAT HAPPENED DURING THIS ACCIDENT: _____

IF YOU HAVE BEEN IN ANY PREVIOUS AUTO ACCIDENTS, PLEASE LIST THE YEAR EACH OF THE ACCIDENTS WAS IN:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

PREVIOUS BACK OR NECK PROBLEMS OR SURGERIES (GIVE DATES):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

HAVE YOU LOST ANY TIME FROM WORK BECAUSE OF THIS ACCIDENT? _____

IF YES, PLEASE GIVE DATES AND NUMBER OF HOURS OF TIME LOST: _____

DOES REPEATED TWISTING OR TURNING MAKE YOUR PAIN WORSE? _____

IF YES, IN WHAT REGION OF YOUR BODY? _____

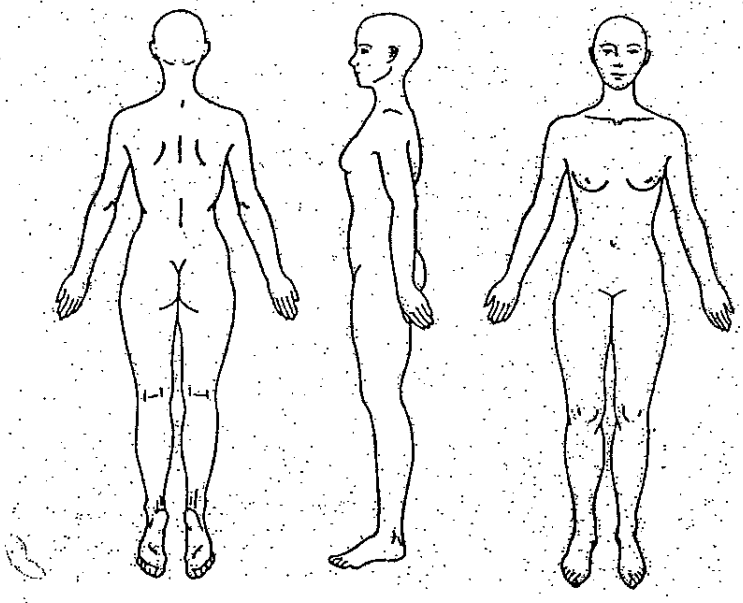
PLEASE CIRCLE THE AREA OF YOUR PAIN OR PAINS AND DRAW A LINE FROM THOSE CIRCLES TO THE DESCRIPTION THAT BEST DESCRIBES THE INTENSITY OF THE PAIN ON THE LEFT AND THE FREQUENCY OF THE PAIN ON THE RIGHT (SEE DEFINITIONS LISTED BELOW):

MILD

SLIGHT

MODERATE

SEVERE



OCCASIONALLY

INTERMITTENT

FREQUENT

CONSTANT

MILD - AN ANNOYANCE WITH NO HANDICAP REGARDING NORMAL FUNCTION.

SLIGHT - TOLERATED PAIN WITH SOME HANDICAP IN THE ACTIVITY THAT PRECEDED THE PAIN.

MODERATE - TOLERATED PAIN, BUT WITH A MARKED HANDICAP IN THE PERFORMANCE OF THE ACTIVITY THAT PRECEDED THE PAIN.

SEVERE - PAIN SO BAD THAT IT WOULD PRECLUDE THE ACTIVITY THAT PRECEDED THE PAIN.

OCCASIONALLY - PAIN PRESENT 25% OF THE TIME.

INTERMITTENT - PAIN PRESENT 50% OF THE TIME.

FREQUENT - PAIN PRESENT 75% OF THE TIME.

CONSTANT - PAIN PRESENT 100% OF THE TIME.

STARTING DATE OF PRESENT SYMPTOMS: _____

HOW LONG HAVE SYMPTOMS BEEN THE SAME? IF THEY ARE CHANGING, DESCRIBE HOW.

_____

IS YOUR PAIN WORSE WHEN ARISING FROM A CHAIR? _____

IS YOUR PAIN WORSE BY STRAINING, COUGHING OR SNEEZING? _____

IS YOUR PAIN SHARP OR DULL? _____

LIEN ON PERSONAL INJURY RECOVERY
(Cal. Civil Code Section 2881(1))

_____("Patient") and_____("Doctor") hereby agree:

TO ESTABLISH A LIEN, pursuant to California Civil Code section 2881, in favor of Doctor in the amount of all such sums as may be due and owing Doctor for services rendered to Patient in connection with the accident ("Accident") in which Patient was involved on_____(Date of Accident) in addition to other amounts, if any, owing to Doctor by reason of other outstanding bills due from Patient to Doctor, **AGAINST ANY AND ALL PROCEEDS** from any insurance policy, settlement, judgment, verdict, or damages payable to Patient in connection with the settlement of claims or litigation arising from the Accident. This lien shall have priority over any subsequent lien or assignment of Patient's interests.

Patient hereby authorizes and directs insurer(s) / responsible party to withhold from any insurance settlement proceeds, judgments, verdicts or other damage awards payable to patient, all sums as may be due and owing Doctor for services rendered to Patient in connection with the Accident, and **to pay directly to Doctor all such sums as may be necessary to fully compensate Doctor.**

Patient understands and acknowledges that Patient remains directly and fully responsible to Doctor for all bills submitted by Doctor for services rendered to Patient, and that this agreement is solely for Doctor's additional protection and in consideration of Doctor's agreement to postpone demand for payment. Patient further understands and acknowledges that Patient's obligation to pay for Doctor's services is not contingent on any settlement, judgment, or verdict by which Patient may recover all or any portion of the sums owed by Patient to Doctor.

DATES:_____ _____
(Patient's Signature)

WITNESSED BY:_____

(3RDPTLN)