16. Where did you go immediately following the accident?_____

17. List each of your body parts that struck the following vehicle parts during the accident:
Dashboard _____ Windshield _____
Steering Wheel _____
Right Door _____ Left Door _____
Seat Frame _____ Unknown Object _____

History of Onset

18. In your own words, please describe the accident:_____
_____
_____

19. Did you have any physical complaints before the accident? _____yes _____no
If "yes", please describe in detail: _____
_____

20. Symptoms since the accident:

__Headache	__Head seems heavy	__Loss of Memory	__Diarrhea
__Neck Pain	__Pins & needles in arms	__Ears Ring	__Indigestion
__Neck Stiffness	__Pins & Needles in legs	__Pain-Walking/Sitting	__High/Low Blood Pressure
__Sleeping Problems	__Numbness in fingers	__Frequent Urination	__Cold Feet
__Back Pain	__Numbness in toes	__Vomiting	__Cold Hands
__Nervousness	__Swelling in joints	__Buzzing in Ears	__Upset Stomach
__Tension	__Shortness of breath	__Loss of balance	__Constipation
__Irritability	__AM or PM Fatigue	__Fainting	__Cold Sweats
__Chest Pain	__Depression	__Loss of Smell	__Fever
__Dizziness	__Vision Changes	__Loss of Taste	__Labored Breathing
__Throat Lump	__Poor Memory	__Cramps	__Painful Breasts
__Hot Flashes	__Sexual Impotency	__Painful Menstruation	__Grinding Teeth
__Hard to get up in the morning			

21. Is your pain constant: ____Yes ____No Is the pain on and off? ____Yes ____No
Is the pain: Sharp? ____Yes ____No Dull?____Yes____No Other?_____

22. Do any of the following ever relieve your pain? ____Heating Pad ____Hot Bath ____Shower ____Ice Pack

23. Do you have any congenital (from birth) factors which relate to this problem? ____Yes ____No If YES, please describe:
_____
_____

24. Do you have any previous illnesses which relate to this cause: ____Yes ____No If YES, please describe:_____
_____

25. Have you ever been involved in a car accident before: ____Yes ____No
If YES, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received:_____
_____
_____
_____

26. Since this injury occurred, are your symptoms: ____Improving ____Getting Worse ____Same

27. Have you lost time from work as a result of this accident? ____Yes ____No
If YES, last day worked?_____
Are you being compensated for time lost from work? ____Yes ____No
If YES, please state the type of compensation you are receiving:_____

28. Do you notice any activity restrictions as a result of this injury? ____Yes ____No If YES, please describe in detail:
_____
_____
_____

29. Other pertinent information:_____
_____
_____

_____ _____
DATE PATIENT'S SIGNATURE