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Personal Injury History

Name: Age: Date of Birth: Male/Female
Address: City/state: Zip:
SS#: Driver's License #:
Your Auto Insurance Company : Phone #:
Name of Agent and/or Adjustor: Claim #:
Do you have an Attorney? Y N Name: Phone #:
3rd Party Auto Insurance Company: Phone #:
Name of Agent and/or Adjustor: Claim #:

Internal Office Use:
Adustor Name & Ph#:
Claims Mailing address:
Claim # verified

SYMPTOMS:

Did you hit your head, arm, chest, leg, etc? Explain:
Were you conscious after accident? Y N Do you remember the impact? Y N
Did you go to the hospital after the accident?
Names of any treating Doctors since accident:
What care were you given since accident?
How did you feel after the accident? Where was the pain?
Does it bother you to ride in a car now as passenger or driver? Y N

ACCIDENT HISTORY:

Date of Accident: Time of Accident: City of Accident:
Did the police arrive? Y N Please bring us a copy of the accident report.
State how the accident happened:
What type of vehicle were you in? Make: Year:
Were you driving? Y N Was it your car? Y N If not, whose car was it?
Were you passenger? Y N Were you rotated in your seat? Y N Were you reclined? Y N
Were other people in the car? Y N
Names, phone numbers, and addresses:
Were they injured? Y N If yes, please explain:

Were you wearing your seat belt? Y N Shoulder harness on? Y N Headrest: high or low
 What were the weather conditions? _____ Traffic Conditions? _____
 Type of road: single lane highway/freeway gravel road Posted speed limit: _____
 Did it happen at a: stop sign traffic light intersection on road How fast were you going? _____
 Was your car hit from the: front back left side right side
 Did your vehicle hit something? Y N If yes : another car sign/pole tree bridge embankment
 If you struck another car, did you strike it on the: front back side
 Did your vehicle go off the road? Y N If yes : into ditch into embankment How Deep? _____
 State any strange events that happened during or immediately after the accident:

In what condition was the vehicle prior to the accident? _____

What was the damage to the vehicle?

Inside: _____ Outside: _____

If there was another vehicle involved, was it a: car truck motorcycle SUV Other: _____

What was the damage to the other vehicle?

Inside: _____ Outside: _____

Do you have pictures of the automobile? Y N

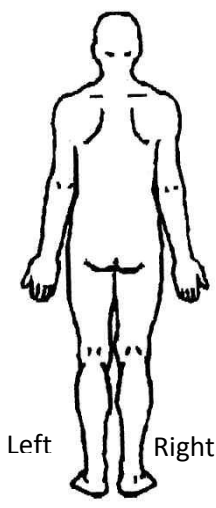
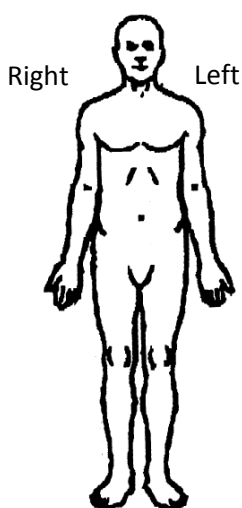
Was an accident report made? Y N Police of City: _____ County: _____ State: _____

Who was ticketed? _____ For what? _____

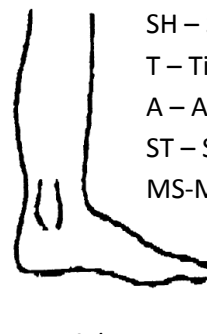
Have you had any time loss from work? Y N If yes, from _____ to _____

INJURY DETAIL:

Please circle area(s) of injury and describe your symptoms using the codes listed below.



Left/Right



Left/Right

- | | |
|-----------------|--------------|
| N- Numbness | TH-Throbbing |
| P – Pain | SW-Swelling |
| ST-Stabbing | D – Dull |
| SH – Sharp | SO-Shooting |
| T – Tingling | B-Burning |
| A – Ache | C-Cramps |
| ST – Stiffness | S – Soreness |
| MS-Muscle Spasm | O-Other |

I attest that the above given information is complete and accurate to the best of my knowledge.

Signature: _____ Date: _____