Do you notice any activities of your home daily routines that are difficult now than from before the accident ? Yes / No

If yes, list them as :

Those that you are unable to do are : (be specific) _____

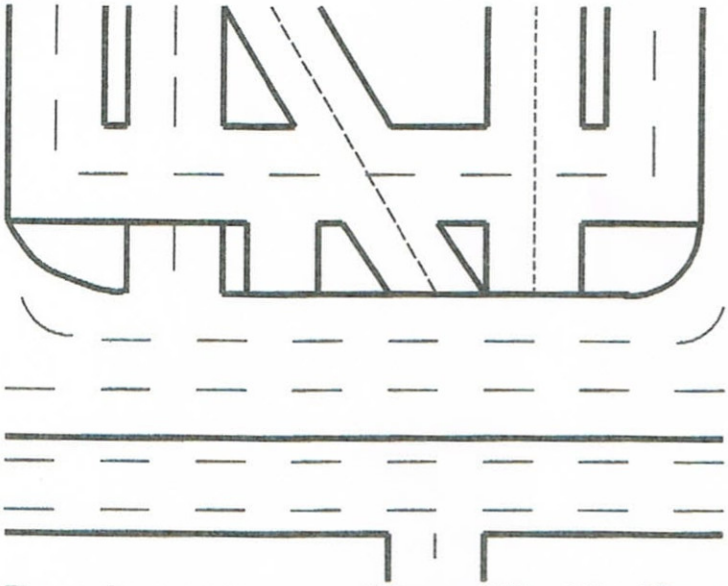
Those that are painful to do are : (be specific) _____

Those that are difficult to do are : (be specific) _____

On a scale from 1 – 5 with 1 being 9examinee's quote) "I'm pain free and can function quite well," and 5 being "I'm in pain all the time and cannot function at all," where would you rate yourself ? 1 2 3 4 5

Please explain why : _____

Relative to where you were before this injury, how would you rate how much you have recovered so far ? _____ %



Indicate on this diagram
How the accident happened

Do you have an attorney on this case ? Yes / No If yes, who ?

Name _____ Address _____

City _____ State _____ Zip _____ Phone _____

Automobile accident – Insurance Information

Patient's Insurance Company Information :

Company Name : _____ Phone : _____ Policy # : _____

Address : _____

Adjuster Name : _____ Claim # : _____

Insured's Insurance Information

Insured's name if different from patient : _____ Phone : _____

Company Name : _____ Phone : _____ Policy # : _____

Address : _____

Adjuster Name : _____ Claim # : _____

Other Driver's Insurance Information

Other driver's name : _____ Phone : _____

Company Name : _____ Phone : _____ Policy # : _____

Address : _____

Adjuster Name : _____ Claim # : _____

_____

Patient Signature Date