

EDWARD MAGAZINER, P.T., M.D.  
2186 ROUTE 27, SUITE 2D  
NORTH BRUNSWICK, NJ 08902

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

INITIAL HISTORY OF CURRENT ILLNESS/COMPLAINTS – AUTO RELATED

AUTO ACCIDENT \_\_\_\_\_ Date of Accident \_\_\_\_\_ Driver/Passenger/Pedestrian

Please circle one of the following:

Vehicle was hit @ A) Passenger front/back B) Drivers side front/back C) Rear D) Head-On

PATIENT'S INJURY

Please indicate location 1-8 if applicable:

Head (face, forehead, nose) struck on _____	1. Dashboard
Neck struck on _____	2. Windshield
Shoulder struck on _____	3. Steering Wheel
Back struck on _____	4. Door
Arms struck on (RT _____ LT _____)	5. Roof of Car
Leg struck on (RT _____ LT _____)	6. Seat Belt
Abdomen struck on _____	7. Front Seat
Side struck on (RT _____ LT _____)	8. Mirror

INJURY RESULTED IN

(please circle)

Dazed \_\_\_\_\_ Loss of consciousness \_\_\_\_\_

IMMEDIATE pain of: HEAD, BACK, NECK, SIDE (Lt / Rt), LEG (Lt / Rt), ARM (Lt / Rt)

DELAYED pain of: HEAD, BACK, NECK, SIDE (Lt / Rt), LEG (Lt / Rt), ARM (Lt / Rt)

Bleeding? \_\_\_\_\_ (If so, where? \_\_\_\_\_)

Where did you go immediately following the accident? \_\_\_\_\_

Were X-rays taken? \_\_\_\_\_ If yes, were injuries noted? \_\_\_\_\_

Was medication prescribed? \_\_\_\_\_ Who referred you to us? \_\_\_\_\_

CURRENT MEDICAL PROBLEMS/COMPLAINTS

HEADACHES Yes No Frequency \_\_\_\_\_

How long? \_\_\_\_\_ Front / Back / Sinuses

NECK PAIN Yes No Going to Lt or Rt Shoulder \_\_\_\_\_  
Back

NUMBNESS/TINGLING/RADIATING PAIN Yes No Where? \_\_\_\_\_

SHOULDER PAIN Yes No Going to Lt or Rt arm? \_\_\_\_\_  
Back

BACK PAIN	Yes	No	Going to:	Upper Back	Lower Back	
				Lt	Rt	ARM
				Lt	Rt	LEG
				Lt	Rt	BUTTOCKS

THE ABOVE PROBLEMS ARE AGGRAVATED BY: (please circle if applicable)

TWISTING TURNING WEATHER BENDING HEAT/LIGHT/COLD

STANDING or SITTING LONG PERIODS OF TIME LIFTING

PIP FORM FOR MOTOR VEHICLE ACCIDENTS

*\*\*\*Please answer EVERY question on this form. DO NOT leave anything blank.\*\*\**

YOUR NAME: \_\_\_\_\_ YOUR SIGNATURE: \_\_\_\_\_

AUTO INSURANCE COMPANY NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

CLAIM #: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

ADJUSTER'S NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

ACCIDENT DATE: \_\_\_\_\_ TIME: \_\_\_\_\_ STATE: \_\_\_\_\_

DESCRIPTION OF ACCIDENT: \_\_\_\_\_

ADDRESS WHERE INJURY OCCURRED: \_\_\_\_\_

DID YOU HAVE X-RAYS TAKEN? \_\_\_\_\_ IF YES, WHERE? \_\_\_\_\_

X-RAY FINDINGS: \_\_\_\_\_

DO YOU HAVE A PRE-EXISTING CONDITION? \_\_\_\_\_ BRIEFLY DESCRIBE: \_\_\_\_\_

WERE YOU UNABLE TO WORK? \_\_\_\_\_ IF YES, FROM DATE: \_\_\_\_\_ THROUGH: \_\_\_\_\_

HAVE YOU RETURNED TO WORK? \_\_\_\_\_ DATE RETURNED TO WORK: \_\_\_\_\_

ARE OTHER PHYSICIANS TREATING YOU? \_\_\_\_\_ IF YES, NAME OF PHYSICIANS: \_\_\_\_\_

ANY SURGERIES DUE TO ACCIDENT? \_\_\_\_\_ IF YES, WHAT DATES & TYPE(S): \_\_\_\_\_

SURGERIES DONE WHERE? \_\_\_\_\_

ATTORNEY'S NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PIP FORM FOR WORKERS' COMPENSATION

*\*\*\*Please answer EVERY question on this form. DO NOT leave anything blank.\*\*\**

YOUR NAME: \_\_\_\_\_ YOUR SIGNATURE: \_\_\_\_\_

EMPLOYER'S NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

EMPLOYER'S INSURANCE COMPANY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

CLAIM #: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

ADJUSTER'S NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

ACCIDENT DATE: \_\_\_\_\_ TIME: \_\_\_\_\_ STATE: \_\_\_\_\_

GIVE A BRIEF DESCRIPTION OF ACCIDENT: \_\_\_\_\_

\_\_\_\_\_

ADDRESS WHERE INJURY OCCURRED: \_\_\_\_\_

DID YOU HAVE X-RAYS TAKEN? \_\_\_\_\_ IF YES, WHERE? \_\_\_\_\_

X-RAY FINDINGS: \_\_\_\_\_

DO YOU HAVE A PRE-EXISTING CONDITION? \_\_\_\_\_ BRIEFLY DESCRIBE: \_\_\_\_\_

WERE YOU UNABLE TO WORK? \_\_\_\_\_ IF YES, FROM DATE: \_\_\_\_\_ THROUGH: \_\_\_\_\_

HAVE YOU RETURNED TO WORK? \_\_\_\_\_ DATE RETURNED TO WORK: \_\_\_\_\_

ARE OTHER PHYSICIANS TREATING YOU? \_\_\_\_\_ IF YES, NAME OF PHYSICIANS: \_\_\_\_\_

\_\_\_\_\_

ANY SURGERIES DUE TO ACCIDENT? \_\_\_\_\_ IF YES, WHAT DATES & TYPE(S): \_\_\_\_\_

\_\_\_\_\_

SURGERIES DONE WHERE? \_\_\_\_\_

ATTORNEY'S NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_