Patient Name _____ Date _____

FILL OUT IF YOU HAVE BEEN IN AN AUTO ACCIDENT

Date and time of accident: _____ ☐ A.M. ☐ P.M.

Has this accident been reported to your auto insurance company? ☐ Yes ☐ No

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear passenger

Make and model of the vehicle you were occupying? _____

Number of people in accident vehicle? _____

Did the police come to the accident site? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Were you wearing a seat belt? ☐ Yes ☐ No

Was this vehicle equipped with airbags? ☐ Yes ☐ No

If yes, did it/ they inflate? ☐ Yes ☐ No

In relation to the base of your skull, where was the headrest? ☐ Above ☐ Below ☐ At base of skull

What did your vehicle impact? ☐ Another vehicle ☐ Other

If other, explain: _____

Did any part of your body strike anything in the vehicle? ☐ Yes ☐ No

If yes, please describe: _____

Make and model of the other vehicle(s) involved? _____

Name of the Location/ Street on which you were traveling?

_____

In which direction were you headed? ☐ N ☐ S ☐ E ☐ W

What was the approx. speed of your vehicle? _____

Did the impact to your vehicle come from the: ☐ Front ☐ Rear ☐ Right Side ☐ Left Side ☐ Other

During impact, were you facing: ☐ Right ☐ Left ☐ Forward

Were you ☐ aware or ☐ surprised by the impact?

If accident vehicle made impact with another vehicle…

Direction other vehicle was headed? ☐ N ☐ S ☐ E ☐ W

Approximate speed of the other vehicle? _____

In your words, please describe the accident:

_____

_____

_____

_____

_____

Patient Name _____ Date _____

After Injury

Did accident render you unconscious? ☐ Yes ☐ No If yes, for how long? _____

Please describe how you felt immediately after the accident: _____

Have you gone to a hospital or seen any other doctor? ☐ Yes ☐ No Transported by? ☐ Ambulance ☐ Self

When did you go? ☐ Just after accident ☐ The next day ☐ 2 days or more

Name of hospital and/ or attending doctor: _____☐ D.C. ☐ M.D ☐ D.O

Describe any treatment you received: _____ Were X-Rays taken? ☐ Yes ☐ No

Was medication prescribed? ☐ Yes ☐ No Type or name of medication(s)_____

Are your work activities restricted as a result of this injury? ☐ Yes ☐ No Unable to work ☐ Yes ☐ No

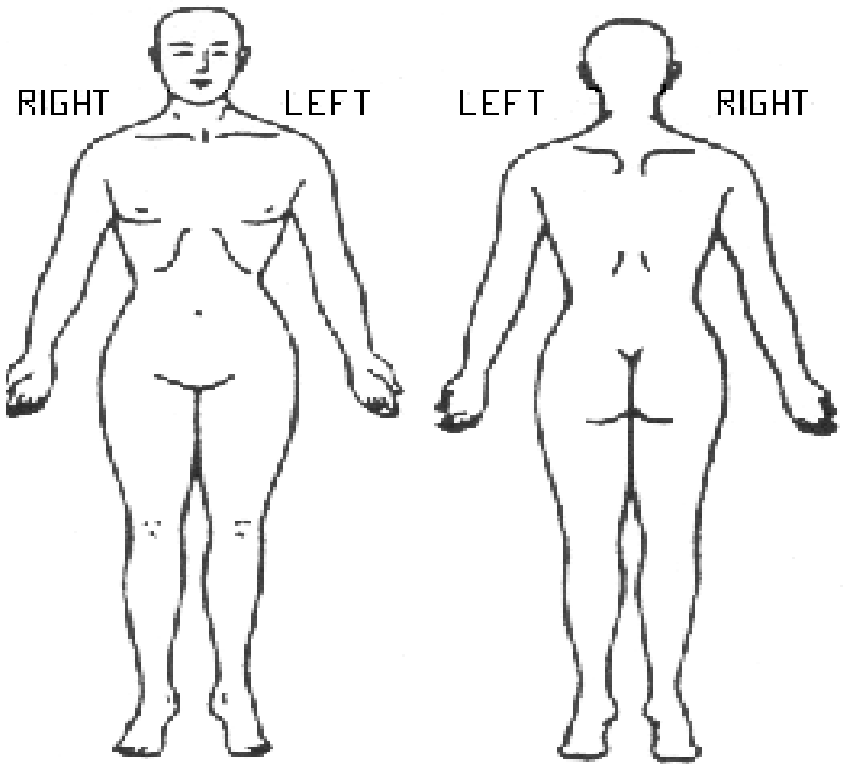
Indicate the symptoms that are a result of this accident:

☐ Dizziness	☐ Difficulty Sleeping	☐ Jaw problems	☐ Nausea
☐ Memory loss	☐ Irritability	☐ Arms/ shoulder pain	☐ Back pain
☐ Headache(s)	☐ Fatigue	☐ Chest pain	☐ Lower back pain
☐ Blurred vision	☐ Tension	☐ Leg pain	☐ Numb arms/hands/fingers
☐ Buzzing in ear	☐ Neck stiff/pain	☐ Shortness of breath	☐ Numb legs/feet/toes
☐ Ears ringing	☐ Stomach upset	☐ Back stiffness	

☐ Other _____

Is your condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

Please circle all areas of pain or injury on the illustrations below to show all symptoms you are experiencing.



Patient Name _____ Date _____

Indicate changes in your condition as a result of the auto accident:

	Uncomfortable	Painful		Uncomfortable	Painful
Lying on back…	☐	☐	Running……	☐	☐
Lying on side…	☐	☐	Sports……	☐	☐
Lying on stomach…	☐	☐	Working……	☐	☐
Sitting……..	☐	☐	Lifting……...	☐	☐
Standing……...	☐	☐	Bending…….	☐	☐
Stretching…….	☐	☐	Kneeling……	☐	☐
Walking……	☐	☐	Pulling……..	☐	☐
Reaching……	☐	☐			

Any other changes in your condition as a result of the accident: _____

_____

Prior to the injury were you capable of working on an equal basis with others your age? ☐ Yes ☐ No ☐ N/A

Have you retained an attorney: ☐ Yes ☐ No

If yes, whom? _____

His/ Her phone #:_____

- We invite you to discuss with us any questions regarding our services. The best services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date _____/_____/_____

☐ Adult patient ☐ Parent or Guardian ☐ Spouse