

CHIROPRACTIC FAMILY HEALTH CENTER

ACCIDENT REPORT

NAME _____ # _____ DATE _____

Date of accident _____ Hour _____ AM/PM Location _____

How did accident occur? Auto collision On the job injury
 Other _____

Please describe the circumstances. _____

Your occupation _____ employed by _____
 employer's address _____

Did you report the injury to your employer? yes no
 Did they recommend care at our office? yes no

If auto accident, were you driver passenger pedestrian.
 If auto collision, were you struck from behind L side R side
 front auto was parked

Did your car strike the other(s) involved? yes no
 or did the other car strike yours? yes no driver's name _____

As a result of the accident, were traffic citations issued to you? yes no
 to the driver of the other car yes no
 to the driver of your car yes no

List the extent of your injuries as you know them _____

Did you require post-accident hospitalization? yes no
 Other doctors you have seen: Dr. _____ Date _____ Treatment _____
 Dr. _____ Date _____ Treatment _____

Check symptoms you have noticed SINCE THE ACCIDENT:

COMPLAINTS:

- SHORTNESS OF BREATH
- EXCESSIVE PERSPIRATION
- MID BACK (PAIN; STIFFNESS)
- LOW BACK (PAIN; STIFFNESS)
- SWELLING (WHERE) _____
- FEET COLD; HANDS COLD
- RESTRICTION OF NECK MOTION
- UPPERBACK PAIN AND STIFFNESS
- BUZZING AND/ OR RINGING IN EARS
- EYES SENSITIVE TO LIGHT, LOSS OF FOCUS
- HEAD AND SHOULDERS FEEL TIRED; HEAVY
- PINS AND NEEDLES IN (ARMS; LEGS)
- NUMBNESS IN (FINGERS; ARMS; LEGS)
- DIFFICULTY IN RIDING IN A CAR
- HEADACHE
- NECK PAIN
- NECK STIFFNESS
- INSOMNIA
- TENSION
- IRRITABILITY

- LOSS OF TASTE
- LOSS OF SMELL
- LOSS OF MEMORY
- DIARRHEA
- NEURITIS
- ANXIETY
- FAINTING
- CHEST PAIN
- DIZZINESS
- CONSTIPATION
- DEPRESSION
- EYESTRAIN
- NAUSEA, VOMITING
- FACE FLUSHED
- PALPITATION
- TREMORS
- SINUS TROUBLE
- MENTAL DULLNESS
- EXTREME NERVOUSNESS
- EXTREME FATIGUE
- PAIN BEHIND EYES

- DOUBLE VISION
- DIGESTIVE DISORDERS
- EQUILLIBRIUM PROBLEMS
- HEAD SEEMS TOO HEAVY
- DIFFICULTY IN EXCESSIVE
 - STANDING WALKING
 - RIDING BENDING
- NECK (PAIN; STIFFNESS) UPON ARISING
- LOW BACK (PAIN; STIFFNESS) UPON ARISING
- PAIN RADIATING INTO ARM; LEG
 - RIGHT; LEFT; BOTH
- DIFFICULTY IN LIFTING
 - LT. MOD.
 - HVY. REPET.
- PAIN RADIATING INTO
 - NECK
 - BASE OF SKULL
 - SHOULDER
 - ARMS
 - HIPS
 - LEGS

SYMPTOMS OTHER THAN ABOVE _____

EMPLOYMENT

Have you lost any days of work because of the accident?

From _____ to _____

Have your work duties been modified at all since the accident?

Describe _____

INSURANCE

If auto accident, whom was at fault Other Driver Yourself

Please give name and location of:

your auto insurance company _____
AND carrier (local agency) _____

other driver's auto insurance company _____
AND carrier (local agency) _____

Personal injury insurance carrier _____
AND address _____

Have you been contacted by an insurance adjustor or company representative regarding this claim? ___yes ___no

Do you have an attorney who has advised you in this case? ___yes ___no

name _____

address _____

phone _____

I understand and agree that insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

signature _____

Auto Accident

Date of accident: _____

Your role was (circle one): Back seat passenger, Front seat passenger, Driver of motorcycle, Other, Driver with (left/right) hand on the wheel, Driver with both hands on the wheel

What was the vehicle's status? _____

What area of the vehicle was impacted? _____

It was (circle one): Dawn, Dusk, Full Daylight, Night

Road conditions were (circle one): Damp, Dry, Icy, Nasty, Snow covered, Wet

Rate the visibility (circle one): Excellent, Fair, Good, Poor

What type was the other vehicle involved? _____

What would you guess was the speed of the other vehicle? (end in 0 or 5) _____

In what position was your headrest? _____

Were you admitted to a hospital? _____ If yes, was it at the time of the accident or at a later time? _____

How did you get to the hospital? _____

What was your attending doctor's name? _____

How many days were you in the hospital? _____

Choose one –

_____ I was able to brace for impact with my (hands, feet, or knees).

_____ I was aware the accident was coming, but unable to brace.

_____ I was not aware the accident was impending.

Circle the problem for the accident:

Brightness, Darkness, Fog, Rain, Snow, Traffic

Where are your injuries? _____
