Accident Information Form

Is condition due to an accident? ☐ Yes ☐ No Date ____________________

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Workers' Comp ☐ Other

Attorney name (if applicable) ____________________

Auto Accident Information:
Time and Date of Present Injury ____________________
Location of Accident

Street ____________________
City ____________________ State ____________________

Estimated speed of your vehicle ____________ Estimated speed of other vehicle ____________
At the time of impact, was the position of your head:
☐ Straight ☐ Turned Left ☐ Turned Right

Were you knocked unconscious? ☐ Yes ☐ No If so, how long? ____________

You were struck from ☐ Behind ☐ Front ☐ Left side ☐ Right side
You were ☐ Driver ☐ Passenger ☐ Front Seat ☐ Back Seat
You were using ☐ Seat belts ☐ Other protective devices

If applicable, indicate any pains or abnormal sensations experienced, immediately following the accident:

☐ Felt no immediate pain
☐ Headache
☐ Semi-conscious state
☐ Mid back pain (R ☐ L ☐)
☐ Upper extremity pain (R ☐ L ☐)
☐ Other

☐ Pain began several hours☐ days☐ weeks☐ after accident
☐ Saw stars
☐ Neck pain (R ☐ L ☐)
☐ Low back pain (R ☐ L ☐)
☐ Lower extremity pain (R ☐ L ☐)

Diagnosis & Treatment After Accident:
Indicate which procedures were performed while at hospital (including emergency room)
☐ X-Rays ☐ Surgery ☐ MRI ☐ Other ____________

Where were you taken after the accident? ____________________
What treatment was given? ____________________
Was any other doctor consulted after your accident? ☐ Yes ☐ No
What was the doctor's name? ____________________ ☐ D.C. ☐ M.D. ☐ D.O. ☐ D.D.S. ☐ P.T.
What procedures were done? ____________________
What was the diagnosis? ____________________
What treatment was given? ____________________
How often did you see the doctor/therapist? ____________________
How long did you see the doctor/therapist? ____________________
Have you ever had any complaints in the involved area before? ☐ Yes ☐ No
If so, what were the complaints? ____________________
Before the injury, were you capable of working on an equal basis with others your age? ☐ Yes ☐ No
Are your work activities restricted as a result of this accident? ☐ Yes ☐ No

Have you lost time from work as a result of this accident? ☐ Yes ☐ No
If Yes, please complete:
Place and type of employment ______________________
Since this injury, are your symptoms ☐ improving? ☐ getting worse? ☐ the same?

I understand and agree that health and accident 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 upon receipt. 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.

Patient Signature ______________________ Date ______________

If patient is under 18:
Guardian Signature ______________________ Date ______________