Motor Vehicle Accident History | Personal Injury

PATIENT NAME			DATE
ADDRESS		CITY	STATE/ZIP CODE
HOME PHONE NUMBER		CELL PHONE NUMBER	
SOCIAL SECURITY	DATE OF BIRTH	AGE	GENDER
E-MAIL ADDRESS:		EMERGENCY CONTACT NAME & PHONE NUMBER:	
EMPLOYER NAME		EMPLOYER ADDRESS	

ACCIDENT INFORMATION

DATE OF ACCIDENT	TIME OF ACCIDENT	WHERE WERE YOU LOCATED IN THE VEHICLE AT THE TIME OF THE ACCIDENT? ☐ Driver ☐ Passenger ☐ Front Seat ☐ Back Seat
NUMBER OF PEOPLE IN THE CAR:		NAMES OF PEOPLE IN THE CAR WITH YOU:
WHAT DIRECTION WAS YOUR CAR HEADED? ☐ North ☐ South ☐ East ☐ West		ON WHAT STREET WERE YOU HEADED?
WHAT DIRECTION WAS THE OTHER CAR HEADED? ☐ North ☐ South ☐ East ☐ West		WERE YOU STRUCK FROM: ☐ Behind ☐ Front ☐ Left Side ☐ Right Side
WERE YOU KNOCKED UNCONSIOUS? Yes / No		DID YOU HIT YOUR HEAD? Yes / No

WHERE WERE YOU TAKEN AFTER THE ACCIDENT?		BY AMBULANCE: Yes / No
WERE THE POLICE ON THE SCENE? Yes / No	WAS A REPORT FILED? Yes / No	DO YOU HAVE A COPY? Yes / No
HAVE YOU BEEN TREATED BY ANY OTHER DOCTORS FOR THIS INJURY/ACCIDENT? Yes / No	SINCE THE INJURY, ARE YOUR SYMPTOMS: ☐ Improving ☐ Getting Worse ☐ Getting Better	
HAVE YOU LOST TIME FROM WORK? Yes / No	DATE YOU LEFT WORK	DATE YOU RETURNED TO WORK

HAVE YOU BEEN INVOLVED IN AN ACCIDENT IN THE PAST? Yes / No	IF YES, PLEASE DESCRIBE
DO YOU HAVE ANY PREVIOUS ILLNESSES WHICH RELATE TO THIS CASE? Yes / No	IF YES, PLEASE DESCRIBE
DO YOU HAVE ANY ACTIVITY RESTRICTIONS AS A RESULT OF THIS INJURY? Yes / No	IF YES, PLEASE DESCRIBE

INSURANCE INFORMATION

INSURANCE COMPANY NAME:	INSURANCE COMPANY PHONE:
ADJUSTER/AGENT NAME:	ADJUSTER/AGENT NAME:
POLICY NAME:	CLAIM NUMBER:

Handy Chiropractic

Dr. James K. Handy

2192 Martin Avenue Suite #155

Irvine, CA 92612

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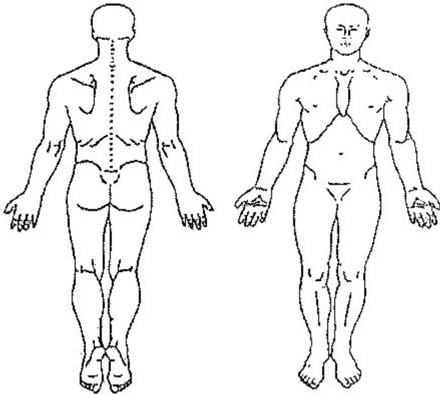
SYMPTOMS

INSTRUCTIONS: Place an "x" next to any/all symptoms noticed after the accident:

	Headache		Dizziness		Light bothers eyes
	Neck pain		Head seems heavy		Ears ring
	Neck stiffness		Pins & Needles in arms		Face flushed
	Sleeping problems		Pins & Needles in legs		Buzzing in ears
	Back pain		Numbness in fingers		Loss of balance
	Nervousness		Numbness in toes		Fainting
	Tension		Shortness of breath		Loss of smell
	Irritability		Fatigue		Loss of taste
	Chest pain		Depression		Upset stomach
	Diarrhea		Feet feel cold		Other:
	Constipation		Hands feel cold		
	Fever		Cold sweats		

INSTRUCTIONS: Please mark the area and type of pain on the drawings using the codes listed below:

N = Numbness **P** = Pain **A** = Ache **T** = Tingling **S** = Stiffness/Soreness



Comments:

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Please provide any other pertinent information you think we should know:

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SIGNATURE

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I agree to notify the doctor whenever I have changes in my health condition or insurance coverage in the future. I have received the Notice of Privacy Practices and have been provided an opportunity to review it.

Patient Signature: ____ Date: ________________

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