



ALLIED SPINE & SPORTS  
— CHIROPRACTIC —  
RELIEVE • RESTORE • RECOVER

100 Intrepid Lane  
Syracuse, NY 13205  
315-498-6888 Phone  
315-498-6889 FAX

Please answer **EVERY** question.

Name \_\_\_\_\_ SS# \_\_\_\_\_

DOB \_\_\_\_\_

Address \_\_\_\_\_

Phone(H) \_\_\_\_\_ (CELL) \_\_\_\_\_

Date of Accident \_\_\_\_\_ Time \_\_\_\_\_

Location \_\_\_\_\_

Area of Complaint \_\_\_\_\_

Describe exactly how the injury occurred / include which body areas are involved:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Workman's Compensation (WCB) Case # \_\_\_\_\_

Insurance Company \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Contact Person \_\_\_\_\_

Insurance Company Carrier Case # \_\_\_\_\_

Employer's Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Contact Person \_\_\_\_\_

Hospitalized? Yes No (CIRCLE) Name of Hospital \_\_\_\_\_

X-rays taken Yes No (CIRCLE) Date \_\_\_\_\_ Location \_\_\_\_\_

Other Doctors seen: \_\_\_\_\_

Are you working now? Yes No (CIRCLE)

Time lost from work: from \_\_\_\_\_ to \_\_\_\_\_

Present work Restrictions \_\_\_\_\_

Do you have an attorney who has advised you in this claim? Yes No (CIRCLE)

Attorney's name \_\_\_\_\_

Phone \_\_\_\_\_

Address \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_