Case #: _____

Back to Wellness Chiropractic
AUTO ACCIDENT INFORMATION

Date and time of accident: _____ □ am □ pm

Were you the: □ Driver □ Front Passenger □ Rear Passenger

Make and model of the vehicle you were occupying? _____

If a traffic violation was issued, to whom was it issued? _____

Number of people in accident vehicle? _____

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

Was a police report filed? □ Yes □ No

Were there any witnesses? □ Yes □ No

Were you wearing a seatbelt? □ Yes □ No

Was the vehicle equipped with airbags? □ Yes □ No

If yes, did it inflate? □ Yes □ No

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

What did your vehicle impact? □ Another vehicle □ Other: _____

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

If yes, explain: _____

_____

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 □ W □ E

What was the approximate speed of your vehicle? _____mph

Did the impact to your vehicle come from the: □ Front □ Rear □ Right side □ Left side □ Other

Were you □ Aware □ Surprised by the impact?

In your words, please describe the accident: _____

_____

_____

_____

AFTER ACCIDENT

Did accident render you unconscious? □ Yes □ No

If yes, for how long? _____

Please describe how you felt immediately after the accident? _____

Case #: _____

Have you gone to a hospital or seen any other doctors? □ Yes □ No

If yes, name of hospital and/or attending doctor(s): _____

Was he/she a: □ D.C. □ M.D. □ D.O. □ Other: _____

When did you go? □ Just after accident □ the next day □ Later: _____

How did you get there? □ Ambulance □ Private transportation

Describe any treatment you received: _____

Were X-rays taken? □ Yes □ No

Was Medication Prescribed? □ Yes □ No

If yes, please list: _____

Have you been able to work since this injury? □ Yes □ No

Are your work activities restricted as a result of this injury? □ Yes □ No

Indicate the symptoms that are a result of this accident:

□ Dizziness	□ Irritability	□ Arms/Shoulder Pain	□ Upper/Mid Back Pain
□ Memory Loss	□ Fatigue	□ Numb Hand/Fingers	□ Low Back Pain
□ Headaches	□ Tension	□ Chest Pain	□ Low Back Stiffiness
□ Blurred Vision	□ Neck Pain	□ Shortness of Breath	□ Hip Pain
□ Ringing in the Ears	□ Neck Stiffness	□ Upset Stomach	□ Leg Pain
□ Difficulty Sleeping	□ Jaw Problems	□ Nausea	□ Numb Feet/Toes

□ Other: _____

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

Indicate your level of comfort while performing these activities:

	Comfortable	Uncomfortable	Painful
Lying on back……	□	□	□
Lying on side ……	□	□	□
Lying on stomach……	□	□	□
Sitting ……	□	□	□
Standing……	□	□	□
Walking……	□	□	□
Running……	□	□	□
Working……	□	□	□
Lifting……	□	□	□
Bending……	□	□	□
Kneeling……	□	□	□
Reaching ……	□	□	□

Case #: _____

Have you retained any attorney? □ Yes □ No

If yes, Name: _____

His/her Phone #: _____

- We invite you to discuss with us any questions regarding our services.
- Our policy requires payment in full for all services rendered at the time of the visit, unless other arrangements have been made. If the 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 charges 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 that it is my responsibility to inform this office of any changes to the information I have provided.

Patient or Guardian Signature _____ Date _____