Chiropractic Care
wellness center

Personal Injury Form

Patient Name:_____ Date:_____

Date of Accident:_____ Time: _____ Location:_____

Were You: □ Driver □ Passenger □ Back Seat

Number of people in your vehicle?_____ Were you wearing a seatbelt? □ Yes □ No

Were you struck from: □ Behind □ Front □ Left Side □ Right Side

Approximate speed of your car _____mph Approximate speed of other car _____mph

Were you knocked unconscious? □ Yes □ No If yes, how long _____

Were the Police notified? □ Yes □ No

In your own words, please describe the accident _____

_____

_____

Did you have any physical complaints BEFORE the accident? □ Yes □ No

Please describe how you felt:

a. During the accident_____

b. Immediately after the accident_____

c. later that day _____

d. the next day_____

What are your present complaints and symptoms? _____

Do you have any congenital (from birth) factors which relate to this problem?

□ Yes □ No If yes, please describe:_____

Do you have any previous illnesses which relate to this case? □ Yes □ No

If yes, please describe _____

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Were you taken to the Hospital after? □ Yes □ No If yes, what hospital?_____

Were you given medications □ Yes □ No If yes, what kind?_____

Have you been treated by another doctor since the accident? □ Yes □ No

If yes, please list doctor's name and address_____

What type of treatment did you receive?:_____

Have you had imaging performed since the accident?: □ Yes □ No

Since this injury occurred, are your symptoms: □ Improving □ Getting worse □ Same

Check the symptoms you have noticed since the accident:

□ Headache □ Irritability □ Ears Ring □ Head Heaviness □ Pins & Needles in Arm

□ Neck Pain □ Chest Pain □ Feet Cold □ Loss of Smell □ Pins & Needles in Legs

□ Neck Stiff □ Dizziness □ Hands Cold □ Loss of Taste □ Numbness

□ Fatigue □ Depression □ Cold Sweats □ Memory Loss □ Shortness of Breath

□ Back Pain □ Fainting □ Stomach Upset □ Finger Numbness □ Difficulty Sleeping

□ Diarrhea □ Fever □ Face Flushing □ Loss of Balance

□ Tension □ Nervousness □ Constipation □ Light Sensitivity

Have you lost time from work as a result of this accident? □ Yes □ No

If yes, when was your last day at work:_____

Have you ever been involved in an accident before? □ Yes □ No

If yes, please describe, including dates(s) and type(s) of accidents, as well as injuries receive

_____

Do you notice any activity restrictions as a result of this injury? □ Yes □ No

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If yes, please describe in detail_____
_____
_____
_____

Please list any other pertinent information:
_____
_____
_____

Insurance Information:

Insurance Company:_____

Claim or Case Number: _____

Adjuster's Name:_____

Address:_____

Phone:_____ Fax:_____

_____ _____

Patient Signature Date

Assignment of Payment:

My attorney and/or insurance carrier are hereby requested and authorized to pay direct to Chiropractic Care Wellness Center any monies due on account, the same to be deducted from any settlement made on my behalf. Further, I agree to pay Chiropractic Care Wellness Center the difference, if any between the total amount of charges on my account and the amount paid by the attorney and/or insurance carrier. It is further understood that I, the undersigned agree to pay Chiropractic Care Wellness Center the full amount of charges on my account should my condition be such that it is not covered by my policy or if for any reason the insurance carrier refuses to pay my claim.

Patient's signature: _____ Date: _____/_____/_____

Printed name: _____

Witness:_____