

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

**INSURANCE INFORMATION**

**Auto Insurance**

*{Complete only if injury is result of an auto accident}*

Subscriber's Name: \_\_\_\_\_ Subscriber's D.O.B.: \_\_\_\_\_

Policyholder SS# \_\_\_\_\_ Policyholders relationship to patient: \_\_\_\_\_

Insurance Co: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Has this accident been reported?  Yes  No

Claim No: \_\_\_\_\_ Date of injury: \_\_\_\_\_

Adjuster: \_\_\_\_\_ Adjuster Phone#: \_\_\_\_\_

**Workers Compensation**

*{Complete only if injury is result of a work related incident}*

Employer: \_\_\_\_\_ Date of Accident: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Has this incident been reported?  Yes  No If yes was treatment authorized?  Yes  No

Insurance Co: \_\_\_\_\_ Phone no: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Claim No: \_\_\_\_\_

Adjuster: \_\_\_\_\_ Phone #: \_\_\_\_\_

**What do you believe is the cause of your pain or condition?**

An automobile accident (Date: \_\_\_\_\_)

A motorcycle accident (Date: \_\_\_\_\_)

A work-related accident (Date: \_\_\_\_\_)

A slip and fall accident (Date: \_\_\_\_\_)

Other: \_\_\_\_\_

What other information is important to your condition? \_\_\_\_\_  
\_\_\_\_\_

**ACCIDENT INFORMATION**

Date of accident: \_\_\_\_\_ Time: \_\_\_\_\_

Were you a passenger in a vehicle?  Did you fall?  Were you a pedestrian?

Were you the driver of a vehicle?  Did an object hit you?  Were you at work?

Other: \_\_\_\_\_  Did you hit an object?

**Were any areas of your body painful shortly after the accident/incident?**

Jaw  Head  Left arm  Left shoulder  Lower back

Face  Neck  Right arm  Right shoulder  Upper back

Other: \_\_\_\_\_

Please describe your accident/incident:

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

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

Did you lose consciousness?  Yes  No, If yes, how long? \_\_\_\_\_

Were you dizzy or confused?  Yes  No

Did you go to the hospital?  Yes  No

If yes, how did you get there?  By car  By ambulance  Other \_\_\_\_\_

If taken by ambulance did they use  a Backboard, or  Neck brace?

Name of hospital taken to: \_\_\_\_\_

How long were you hospitalized for? \_\_\_\_\_

If you have had a previous accident(s) or incident(s) please list the date and a detailed description of your accident(s):

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

Name(s), address(s), and phone number(s) of hospital and/or doctors where you were treated for this previous accident or incident: \_\_\_\_\_

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

If you were in a vehicle, where was the vehicle hit?

At front end  At rear end  On the driver's side  On passenger's side

Head on  Other: \_\_\_\_\_

Were you wearing your seat belt?  Yes  No Was anyone else hurt in the accident?  Yes  No

If yes, please list names of others involved and their relationship to you: \_\_\_\_\_

\_\_\_\_\_

Were you cited with a traffic violation?  Yes  No

Was the driver of the vehicle in which you were a passenger cited with a traffic violation?  Yes  No

Was the driver of the other vehicle cited with a traffic violation?  Yes  No

Did you hit your head?  Yes  No If yes, please check the following information.

	Steering wheel	Windshield	Passenger's side window	Driver's side window	Headrest	Seat	Roof	Other
Forehead								
Face								
Chin								
Right side of head								
Left side of head								
Back of head								
Top of head								
Teeth								
Jaw								
Other								

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