

DeCrescenzo Chiropractic

Auto Injury Form

GENERAL INFORMATION

Date: ___/___/2011

Full Name: _____ **SS #:** _____
First Name Middle Name Last Name

Address: _____
No Street Name Apt No City State Zip Code

Age: _____ **Date of Birth:** _____ **Sex:** Male Female **Marital Status:** _____

Home Phone: _____ **Cell Phone:** _____

Work Phone: _____ **Email Address:** _____@_____.com

Employer: _____ **Occupation:** _____

Emergency Contact: _____ **Relation:** _____

Contact Phone: _____

ACCIDENT INFORMATION:

Date of accident: _____ **Make & model of the vehicle you were in:** _____

Make & model of the other vehicle: _____ **Speed of the other vehicle:** _____

Were you the: Driver Front Passenger Rear Passenger Pedestrian

How many people were in the vehicle at the time of the accident? _____

Were you wearing a seat belt? Yes No If yes, what type: Lap Shoulder

Did the airbags deploy? Yes No **Are there any injuries from the airbag?** _____

Was your vehicle stopped moving at the time of impact? _____ **Speed you were traveling?** _____

Were you: Surprised by impact braced for impact

At the time of impact were you: _____

Looking straight ahead Looking to the left Looking to the right Looking down Looking up

Was impact from: Front Rear Left Right other: _____

Did your car impact another vehicle? Yes No **Did your car impact a structure?** Yes No

Please describe the accident in your own words: _____

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

If yes, explain: _____

PATIENT CONDITION & TREATMENT:

Did you lose consciousness? Yes No If yes, for how long? _____

What were your symptoms following the accident? _____

Did you go to the hospital? Yes No If yes, name of hospital: _____

When did you go? Immediately after accident Later that day Next day other: _____

Were you ambulated to the hospital? Yes No Do you have any of the following: Cuts Scrapes Bruises

Were x-rays performed? Yes No If yes, which body part? _____

Were any other tests performed? Yes No If yes, what tests? _____

Was medication prescribed? Yes No If yes, what medications? _____

Are you pregnant? Yes No If yes, due date: _____

SYMPTOMS/INJURIES:

Have you been able to work since this injury? Yes No How many work days have you missed? __

Please check your symptoms since your injury:

Arm/shoulder pain Neck pain Neck stiffness Hand/finger numbness

Feet/toe numbness Headaches Jaw problems Leg pain Knee/Ankle pain

Shoulder pain Mid-back pain Back stiffness Chest pain Low back pain

Dizziness Nausea Fatigue Sleep difficulty Abdominal pain

Difficulty turning head to the right/left Vision blurred Hearing loss / Balance

Does coughing/sneezing increase your pain? Yes No

Are your symptoms getting worse? Yes No Is it constant or does it come and go? _____

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: Sharp Cramping Dull Throbbing Burning Stabbing Grabbing

INSURANCE/ATTORNEY INFORMATION:

What is the name of your auto insurance?

What is your policy #? _____

What is your claim #: _____

Do you have an Attorney? Yes No

If yes, what is his/her name? _____

Do you have health insurance? Yes No

If yes, please give your insurance card to the front desk.

POLICE:

Did the police come to the accident site? Yes No

Were there any witnesses? Yes No

Was a police report filed? Yes No

If yes, please give the front desk a copy

Was a traffic violation issued? Yes No

If yes, to whom? _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

HEALTH HISTORY:

What treatment have you already received for your condition?

Medications Surgery Physical Therapy Chiropractic Services None other: _____

Name and address of other doctor(s) who have treated you for your condition _____

Please check off your medical history:

- | | | | | |
|---|---|--|---|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Anemia | <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Fractures |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Goiter | <input type="checkbox"/> Gout | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Herniated Disk | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Parkinson's disease | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Prostate Problem | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Tumors, Growths |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Other: _____ | | |

MEDICATIONS:

ALLERGIES:

VITAMINS/HERBS/MINERALS:

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient