DeCrescenzo Chiropractic

Auto Injury Form

GENERAL INFORMATION

Date: __/____/2011__

Full Name: ______________________________________ **SS #:** _______________________

First Name Middle Name Last Name

Address: ____

№ Street Name Apt № 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 (lease 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 Patent, 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:

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

MEDICATIONS:	ALERGIES:	VITAMINS/HERBS/MINERALS:
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

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