DeCrescenzo Chiropractic

Auto Injury Form

GENERAL INFORMATION

Date: __/__/20__ Referred by: _____

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: _____ Contact Phone _____ Relation: _____

Primary Care Physician _____ Address_____ Phone #_____

ACCIDENT INFORMATION:

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

Were you a pedestrian:_____ Name of your own Auto Insurance Co:_____

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

City & State the accident occurred: _____

Which Police Dept. responded to the seen:_____ Was a report filed:_____

Were you punched in (on the clock) for work at the time of the accident? Yes No

Were you in a company Vehicle? Yes No Was this accident in a parking lot? Yes No

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: _____

Transported by ambulance? □ 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: _____

Do you smoke? □ Yes □ No If yes, how much: _____ Drink alcohol? □ Yes □ No If yes, how much: _____

SYMPTOMS/INJURIES:

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

Please circle your symptoms since your injury:

□ Headaches Neck pain □ Neck stiffness □ Jaw problems

left/right Arm pain □ left/right Shoulder pain left/right Hand/finger pain/numbness

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

left/right Leg pain left/right Knee/Ankle pain left/right Foot/Toe pain/numbness

□ 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) _____

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