

DeCrescenzo Chiropractic

Personal Injury Form

GENERAL INFORMATION

Date: ___ / ___ /20___ Referred by: _____

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: _____

Primary Care Physician _____ Address _____ Phone# _____

INJURY INFORMATION:

Date of incident: _____

Where did injury occur: _____

City & State the injury occurred: _____

Please describe the incident in your own words: _____

Did any part of your body strike anything? Yes No If yes, explain: _____

Who is responsible for your injuries: _____

Did injury occur at a business establishment? Yes No

If Yes, Name and address of business: _____

Do you know the insurance information of the responsible party? Yes No

If yes, please list Name, Address and Phone Number of Insurance Company: _____

Did police arrive on scene? Yes No

Was a police Report filed? Yes No

Did you have immediate pain following the incident? Yes No

Are your symptoms affecting your daily activities? Yes No

PATIENT CONDITION & TREATMENT:

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

What were your symptoms following the incident? _____

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 check 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 (least pain) to 10 (severe pain) _____

INSURANCE/ATTORNEY INFORMATION:

Has a claim been filed with an insurance company?

Yes No

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

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