DeCrescenzo Chiropractic

Personal Injury Form

GENERAL INFORMATION

Date: __/____/23_____ 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: ______ 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 Hip 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) __________________

Type of pain: □Sharp □Cramping □Dull □Throbbing □Burning □Stabbing □Grabbing

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 Patent, Parent, Guardian or Personal Representative Relationship to Patient