Back to Health Chiropractic - Auto Accident Form

Patient Name: _____ Date: _____

Age: _____ Birth Date: _____/_____ /_____ ❑ M ❑ F S.S.#: _____

Address: _____

City: _____ State: ___ Zip: _____ Driver's License #: _____

Insured: _____ Address: _____

Name of Insurance Company: _____

City: _____ State: _____ Zip: _____ Telephone #: _____

(If home injury, Home Owner's Policy may be responsible for payment.)

Have you retained an attorney? ❑ Yes ❑ No Name of Attorney: _____

Address of Attorney: _____

Date of Accident: _____ / _____ / _____ Time of Accident: _____ ❑ A.M. ❑ P.M.

Where did the accident happen? _____

Where were you taken after the accident? _____

Where did you feel pain? _____ Were you unconscious? ❑ Yes ❑ No

What are your present symptoms? _____

Are your symptoms: ❑ Improving? ❑ Getting Worse? ❑ Same? ❑ Other? _____

Name(s) of any other doctors consulted since your accident: _____

Treatment received: _____

How often did you receive treatment from the other doctor? _____

Have you previously been injured in a similar manner? ❑ Yes ❑ No

PLEASE EXPLAIN FULLY HOW YOUR ACCIDENT HAPPENED: _____

_____

_____

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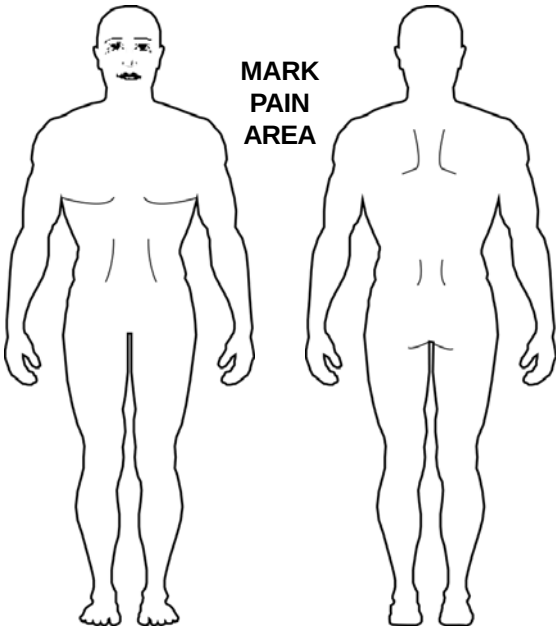

+++ Burning **000 Stabbing**
--- Sharp **III Consistent**

Date: _____ Patient Signature: _____

Date: _____ Patient Signature: _____