BluegrassChiropractic | ACCIDENT INJURY FORM

(Please fill out all content and print clearly)

Patient Name _____Phone_____

Date of Accident _____ Hour _____ AM ____ PM ____ Location _____

How did Accident Occur? Auto Collision ____ On-the-job Injury ____ Other ____

If other, please describe the circumstances _____

Did you report the injury to your foreman or employer? YES ____ NO ____

If this was an auto accident, were you the: Driver____ Passenger____ Pedestrian _____

If auto collision, were you struck from: Behind____ Front____ Right Side____ Left Side____ Auto Was Parked ____

List the extent of the injuries as you know them_____

_____

Insurance Companies involved

_____ Claim # _____

Your Insurance Company _____Adjuster Name _____

Other insurance company responsible for injuries? _____

Have you been contacted by an insurance adjuster or company representative regarding this claim? YES ____ NO _____

Attorney Name _____Number _____

Telephone _____ Date_____

Patient Condition

Reason for Visit_____

When did your symptoms appear?_____

Is this condition getting progressively worse? ❑ YES ❑ NO ❑ UNKNOWN

Mark an X on the picture below where you continue to have pain, numbness, or tingling. Then circle the number which best indicates the severity of your pain on a scale from 1 (least) to 10 (severe):

1 2 3 4 5 6 7 8 9 10

What aggravates your condition? _____

Is it constant or does it come and go? _____

Does it interfere with your: ❑ Work ❑ Sleep ❑ Daily Routine ❑ Recreation

Check activities or movements that are painful to perform:

❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying Down ❑ Turning

Type of Pain: Rate from 1-10 below

_____ Sharp
_____ Dull
_____ Throbbing
_____ Numbness
_____ Aching
_____ Burning
_____ Shooting
_____ Tingling
_____ Cramps
_____ Stiffness
_____ Swelling
_____ Other