AUTO INJURY INFORMATION

Bay Area Chiropractic 10785 Ulmerton Road Largo Florida 33778

Name_____ Today's Date_____

Date of Accident_____ Type of Accident ( )Auto ( )Work/On Job ( )At Home ( )Other_____

Time of Accident_____ AM / PM Location of Accident_____

Describe How Accident Happened _____

_____

_____

Did you go to the hospital? ( )Yes ( )No Name of Hospital_____ Attended by Dr._____

Were you X-rayed ( )Yes ( )No If so, what was the diagnosis_____

Other procedures performed_____

Were you admitted to the hospital? ( )Yes ( )No For how long_____ Any recommendations made_____

List any other doctors you have seen as a result of this accident_____

_____

Have you lost time from work ( )Yes ( )No Totally Disabled _____-_____ Partially Disabled _____-_____

Have you returned to work since the accident ( )Yes ( )No Please list job duties:_____

_____

What kind of vehicle were you in?_____ Wearing seat belt ( )Yes ( )No

What kind of vehicle hit yours?_____ Were you: ( )Driver ( )Passenger ( )Pedestrian

Did your vehicle strike the other vehicle? ( )Yes ( )No or Did the other vehicle strike yours? ( )Yes ( )No

Estimated Speed upon impact: Your Vehicle_____mph Other Vehicle_____mph

Upon impact, did you strike any part of your body on the interior of your car? Describe_____

_____

Did you lose consciousness? ( )Yes ( )No If so, for how long_____

Were you cut or bruised? ( )Yes ( )No If so, where_____

Did you require post-accident hospitalization? ( )Yes ( )No Describe_____

PLEASE CHECK ALL SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

( )Headache	( )Irritability	( )Numbness in Toes, L/R	( )Face Flushed	( )Feet Cold, L/R
( )Neck Pain	( )Chest Pain	( )Shortness of Breath	( )Buzzing in Ears	( )Hands Cold, L/R
( )Neck Stiff	( )Dizziness	( )Fatigue	( )Loss of Balance	( )Upset Stomach
( )Depression	( )Head Seems Heavy		( )Fainting Spells	( )Constipation
( )Back Pain	( )Pins & Needles in Arms, L/R		( )Loss of Memory	( )Sleeping Problems
( )Nervousness	( )Pins & Needles in Legs, L/R		( )Light Bothers Eyes	( )Cold Sweats
( )Tension	( )Numbness in fingers, L/R		( )Ears Ringing	( )Loss of Taste
( )Loss of Smell	( )Fever			

Any other symptoms not listed above?_____

_____

ON A SCALE OF 1-10 {1=MINIMAL PAIN, 10=MAXIMUM PAIN} PLEASE RATE YOUR CURRENT PAIN LEVEL:

_____Headache _____Neck Pain _____Mid Back Pain _____Low Back Pain _____Left Shoulder Pain

_____Right Shoulder Pain _____Left Arm Pain _____Right Arm Pain _____Left Leg Pain _____Right Leg Pain

_____(Other, Please Describe)_____

Please Complete Both Sides

Name of Your Auto Insurance Company _____ Policy #_____

Claim #_____ Phone #_____ ext._____

Adjuster's Name_____ Address _____

Name of Person who owned vehicle that you were in at time of accident_____

Name of Driver (if other than self) at time of accident _____

Name of Driver's Auto Insurance Co. _____ Policy #_____

**If you did not own your own vehicle at the time of the accident or did not have auto insurance at the time of the accident, did you live with a relative or spouse who had auto insurance at the time of the accident? ( )Yes ( )No

Name of relative_____ Relative's Auto Insurance Co._____

Policy #_____ Claim #_____ Phone #_____

Have you been contacted by any insurance adjuster or company representative? ( )Yes ( )No

Do you have any attorney who has advised you in this case? ( )Yes ( )No Name_____

Attorney's Phone # _____ Address_____

Is there any other information regarding this accident that you would like for us to know?_____

_____

Patient's Signature_____ Date_____

Doctor's Comments

_____

_____

_____

_____

_____

Please Complete Both Sides