ACCIDENT INJURY FORM

NAME: _____ Todays' Date_____
Date of Injury_____ Hour: _____ AM PM
Where did accident happen? Describe the accident in your own words:

My claim number for this accident: _____
Name of attorney if you have one: _____
Attorney's phone number: _____
Name of the insurance that will be paying for my care: _____
Phone number of insurance company: _____
Fax number: _____
Adjustor's name: _____
Adjustor's phone number: _____
*Do you have your Declarations page? □ Yes □ No
Please hand it to the front desk so we can make a copy. Otherwise, you will need to bring it in on the 2nd visit
*I do understand that after 15 days, if I have not supplied Nob Hill Chiropractic with the missing information listed above, as well as my declarations page of my insurance contract, I am responsible to pay for my treatments(s) out of pocket or using my health/major medical insurance. _____ (Initial)

What was your position in the car?
□ Driver: if Driver were your hands on the steering wheel? □ Left □ Right □ Both
□ Passenger: If passenger, were you sitting in □ Front □ Right Rear □ Left Rear
Did your vehicle strike another vehicle □ Yes □ No
Was your vehicle struck by another vehicle □ Yes □ No
Angles of impact… First Collision: □ Front □ Back □ Left □ Right
If Second Collision: □ Front □ Back □ Left □ Right
Were you wearing a seat belt? □ Yes □ No
Did the airbag deploy? □ Yes □ No
Did you brace for impact? □ Yes □ No … □ I braced with my hands □ I braced with my feet
Which way were you facing at the time of impact… □ straight ahead □ Left □ Right
Did you strike anything in vehicle at time of impact? □ Yes □ No
If yes, specify what part of your body struck what: (example: head hit the left side of the car door)
_____
Did the seat back bend / break ? □ Yes □ No
Immediately following the accident, how did you feel? □ dizzy/dazed □ disoriented □ unconscious
□ nervous □ nauseous □ upset □ weak □ Other _____
As a result of the accident, were citations issued to you? □ Yes □ No
Were citations issued to the driver of the car? □ Yes □ No
Have you seen any other doctor as a result of this accident? □ Yes □ No
Doctor's name : _____
List the extent of your injuries as you know them: _____
_____

Did you require Hospitalization? □ Yes □ No Did you get x-rays take? □ Yes □ No

Where did you have the x-rays done? _____ (if you can bring them in for your next visit, this would be beneficial as hospitals often don't respond quickly to your requests for your reports).
What were the results of the treatment (if you saw a doctor)? _____
Are you taking any medications? ☐ Yes ☐ No if so, what: _____
_____

Please circle anything that you have noticed since the accident:
Numbness: ☐ Yes ☐ No ☐ Left Hand ☐ Left Upper Arm ☐ Right Hand ☐ Right Upper Arm
☐ Left Foot ☐ Left Leg ☐ Right Foot ☐ Right Leg
Lower back pain: ☐ Yes ☐ No
Radiates to (if any): ☐ none ☐ buttocks ☐ left buttock ☐ left thigh ☐ left knee ☐ left foot ☐ right buttock ☐ right thigh ☐ right knee ☐ right foot

Headaches	Pins and needles in the arms	Fatigue
Neck stiffness	Hip pain	Diarrhea
Upset Stomach	Foot pain	
Shortness of breath	Knee Pain	Cold feet or hands
Fainting	Depression	Shoulder pain
Cold sweats	Buzzing or ringing in ears	Constipation
Dizziness	Memory loss	Fever
Sensitive to light	Sleeplessness	Chest pain
Head too heavy	Loss of balance	Neck pain
Blurry vision	Wrist pain	Jaw pain

Additional Symptoms/ Complaints:

Have You lost any time from work due to your injuries? ☐Yes ☐No
If yes please give dates: ___/___/_____and___/___/___and___/___/___/____and___/___/___/___
Type of employment: _____
Have you had previous injuries or accidents? ☐Yes ☐ No
Description of previous Accident: _____
Description of previous injuries: _____
Is there any residual pain from the previous injury? ☐Yes ☐No
How much better did you feel prior to your current condition? (Example 100%, 80% etc.) _____

Patient signature: _____
Date: _____

*This is required in order for us to be able to verify your benefits and to bill the insurance on your behalf.