

Applegate Clinic of Chiropractic

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ACCIDENTAL INJURY FORM

NAME _____ DATE _____

Type of accident: Auto Worker's Compensation Fall Other _____

Date of accident: _____ Time: _____ AM PM

Location of accident: _____

Brief description of accident: _____

Have you lost any days of work? Yes No Dates: _____

AUTO ACCIDENT SECTION:

Your position in the vehicle: Driver Passenger Back Seat Pedestrian

Did the vehicle have seatbelts? Yes No Were seatbelts worn? Yes No

Were you struck from: Behind Head-on Left side Right side Auto was stopped

If applicable, top of headrest was aligned with: top middle bottom of head.

List any parts of your body that made contact with vehicle parts: _____

Were you braced for impact? Yes No Were brakes applied? Yes No

Where were you looking? Rear-view mirror Left door mirror Right door mirror Forward

Were traffic citations issued to you? Yes No Issued to driver of other car? Yes No

Did you require post-accident hospitalization? Yes No

Any previous motor vehicle accidents? Yes No Describe (using dates): _____

If yes, was treatment rendered previously? Yes No Describe (include date and Dr. name): _____

WORKER'S COMPENSATION SECTION:

Did you report the injury to your employer? Yes No

Did they recommend care at this office? Yes No

Employer: _____ Address: _____

CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT

- Headache
- Neck Pain
- Neck Stiffness
- Dizziness
- Back Pain
- Nervousness
- Tension
- Irritability
- Chest Pain

- Sleeping Problems
- Head Feels Heavy
- Pins & Needles in Arms
- Pins & Needles in Legs
- Numbness in Fingers
- Numbness in Toes
- Shortness of Breath
- Fatigue
- Depression

- Lights Bother Eyes
- Loss of Memory
- Ears Ringing
- Face Flushed
- Buzzing in Ears
- Loss of Balance
- Fainting
- Loss of Smell
- Loss of Taste

- Diarrhea
- Feet Cold
- Hands Cold
- Stomach Upset
- Constipation
- Cold Sweats
- Fever
- Other

INSURANCE INFORMATION:

Your Insurance Company: _____ Address: _____

Other Party's Name: _____ Address: _____

Other Party's Insurance Co.: _____ Address: _____

Have you been contacted by an insurance adjustor regarding this claim? Yes No

If yes, name of adjustor: _____ Company: _____

Do you have an attorney that has advised you in this case? Yes No

If yes, Attorney's name _____ Address _____ Phone _____

SIGNATURE: _____