AUTOMOBILE ACCIDENT INFORMATION

The following information is needed for our files so we can better serve you as a patient. Please fill in all portions of the form
If you need any help, please ask the receptionist.

PATIENT DATA Date of Information_______/________/_______

NAME ______________________________ HOME PHONE: (_____)___________________

ADDRESS ______________________________ CITY ______________________ STATE, ____ ZIP _________

AGE_______ BIRTH DATE______/_______/______ MARITAL STATUS ____________________ NUMBER OF CHILDREN _________

OCCUPATION ________________________ EMPLOYED BY ____________________________ SS# _______-_________-________

NAME OF NEAREST RELATIVE ____ WORK PHONE (_____)________________

NAME OF WIFE OR HUSBAND_____________________ OCCUPATION____________________ EMPLOYER _________________

SS# ______-________-_________

INSURANCE DATA

Clinic policy requires payment arrangements be made on first visit.

YOUR AUTO INSURANCE CO_______________________________ POLICY NO._______________ CLAIM NO._____________

INSURANCE ADJUSTOR/AGENT ____ PHONE NO.(_____)________________

OTHER INVOLVED VEHICLE INSURED BY______________________________________ POLICY NO. ______________________

PLEASE LIST ALL SOURCES OF INSURANCE: EMPLOYEE I.D. NO.__________________

· GROUP INSURANCE ____________________________________ POLICY NO. _________________________

· SPOUSE'S INSURANCE_________________________________ GROUP NO.___________________________

· OTHERS ____

DO YOU HAVE AN ATTORNEY THAT HAS ADVISED YOU IN THIS CASE? ☐ YES ☐ NO

ATTORNEYS NAME__________________________ ADDRESS____________________________ PHONE(____)_____________

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize Dr. Allen to treat my condition as he deems appropriate through the use of Chiropractic Health Care. The doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

PATIENT'S SIGNATURE____DATE____________________________

DATE OF ACCIDENT:____/_____/_______ LOCATION ____ HOUR ______ AM / PM

PLEASE EXPLAIN HOW ACCIDENT HAPPENED ____

____

____

____

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____

Andover Family Chiropractic
229 N. Andover Road, Suite 200, Andover, KS 67002
(316)733-0715

ACCIDENT DETAILS

1. Were you: Driver / Passenger (Front) / Passenger (Rear) / Pedestrian
2. Were you wearing seatbelts? (Y / N)
3. Type of vehicle: Auto / Truck / Van / Motorcycle / Motor home / Bicycle
4. How accident occurred: Struck by another vehicle / Struck another vehicle / Struck a stationary object / Other
5. Where was your vehicle hit? Front / Rear / Rt. Side / Left Side / Rt. Front / Left Front / Rt. Rear / Left Rear
6. Where was the other vehicle hit? Front / Rear / Rt. Side / Left Side / Rt. Front / Left Front / Rt. Rear / Left Rear
7. Your approximate speed __________ MPH Other vehicle approximate speed ___________________ MPH
8. What occurred at the moment of impact?? (Circle as *many* as *apply)*

Tensed body for impact	Neck whipped forward & back	Spine torque and twisted	Thrown over seat
Thrown from vehicle	Pinned in vehicle	Thrown from side to side	Cut and bruised

9. Did you strike your (Circle as many as apply)

Head	Left / Right	Against the	Dashboard	Windshield	Steering Wheel	Rt. Door	Left Door	Seat Frame	Unknown Object
Shoulder	Left / Right	Against the	Dashboard	Windshield	Steering Wheel	Rt. Door	Left Door	Seat Frame	Unknown Object
Arms	Left / Right	Against the	Dashboard	Windshield	Steering Wheel	Rt. Door	Left Door	Seat Frame	Unknown Object
Elbow	Left / Right	Against the	Dashboard	Windshield	Steering Wheel	Rt. Door	Left Door	Seat Frame	Unknown Object
Wrist	Left / Right	Against the	Dashboard	Windshield	Steering Wheel	Rt. Door	Left Door	Seat Frame	Unknown Object
Hip	Left / Right	Against the	Dashboard	Windshield	Steering Wheel	Rt. Door	Left Door	Seat Frame	Unknown Object
Knee	Left / Right	Against the	Dashboard	Windshield	Steering Wheel	Rt. Door	Left Door	Seat Frame	Unknown Object
Ankle	Left / Right	Against the	Dashboard	Windshield	Steering Wheel	Rt. Door	Left Door	Seat Frame	Unknown Object

10.Were you rendered unconscious? (Y / N) Did you receive medical attention at the scene of the accident? (Y / N)
11 Where did you go immediately following the accident? Hospital / Home / Personal doctor / To this office / Resumed activities
12. Were you: (Circle as many as apply) Shaken / Disoriented

Check Symptoms You Have Noticed Since the Accident

☐ SHORTNESS OF BREATH
☐ EXCESSIVE PERSPIRATION
☐ MID BACK (PAIN; STIFFNESS)
☐ LOW BACK (PAIN; STIFFNESS)
☐ SWELLING (WHERE)__________
☐ FEET COLD; HANDS COLD
☐ RESTRICTION OF NECK MOTION
☐ UPPER BACK PAIN & STIFFNESS
☐ BUZZING & OR RINGING IN EARS
☐ EYES SENSITIVE TO LIGHT, LOSS OF FOCUS
☐ HEAD & SHOULDERS FEEL TIRED; HEAVY
☐ PINS & NEEDLES IN (ARMS; LEGS)
☐ NUMBNESS IN (FINGERS; ARMS;LEGS)
☐ DIFFICULTY IN RIDING IN CAR
☐ HEADACHE
☐ NECK PAIN
☐ NECK STIFFNESS
☐ INSOMNIA
☐ TENSION
☐ IRRITABILITY
☐ LOSS OF TASTE

☐ LOSS OF SMELL
☐ LOSS OF MEMORY
☐ DIARRHEA
☐ NEURITIS
☐ ANXIETY
☐ FAINTING
☐ CHEST PAIN
☐ DIZZINESS
☐ CONSTIPATION
☐ DEPRESSION
☐ EYESTRAIN
☐ NAUSEA, VOMITING
☐ FACE FLUSHED
☐ PALPITATION
☐ TREMORS
☐ SINUS TROUBLE
☐ MENTAL DULLNESS
☐ EXTREME NERVOUSNESS
☐ EXTREME FATIGUE
☐ PAIN BEHIND EYES
☐ DOUBLE VISION

☐ DIGESTIVE DISORDERS
☐ EQUILIBRIUM PROBLEMS
☐ HEAD SEEMS TOO HEAVY
☐ DIFFICULTY IN EXCESSIVE
  ☐ STANDING ☐ WALKING
  ☐ RIDING ☐ BENDING
☐ NECK (PAIN;STIFFNESS) UPON RISING
☐ LOW BACK (PAIN;STIFFNESS) UPON RISING
☐ PAIN RADIATING INTO ☐ ARM ☐ LEG
  ☐ RIGHT ☐ LEFT ☐ BOTH
☐ DIFFICULTY IN LIFTING
  ☐ LIGHT ☐ MODERATE
  ☐ HEAVY ☐ AFTER A FEW TIMES
☐ PAIN RADIATING INTO:
  ☐ NECK
  ☐ BASE OF SKULL
  ☐ SHOULDER
  ☐ ARMS
  ☐ HIPS
  ☐ LEGS
  ☐ FEET

SYMPTOMS OTHER THAN ABOVE, ____
HAVE YOU LOST ANY DAYS WORK? DATES: FROM______________________________ TO ______________________

PRIOR TO THIS ACCIDENT, WERE YOU EXPERIENCING SIMILAR COMPLAINTS ☐ YES ☐ NO
LIST OTHER DOCTORS SEEN FOR THIS CONDITION____
WHAT MEDICATIONS OR DRUGS ARE YOU TAKING?____

HABITS		EXERCISE	FAMILY HISTORY					
				Diabetes	Heart	Kidney	Cancer	Back
☐Smoking	_____pks/day	☐ None	Mother	☐	☐	☐	☐	☐
☐Drinking	_____Alcohol	☐ Moderate	Father	☐	☐	☐	☐	☐
☐Coffee	_____cups/day	☐ Daily	Brother No. of ____	☐	☐	☐	☐	☐
			Sister No. of _____	☐	☐	☐	☐	☐