Rockside Chiropractic Life Center

ACCIDENTAL INJURY REPORT

If your clinic visit is due to an accident, please describe all events associated with it.

Date of Accident: _____ Hour of Accident: _____ AM PM

Type of Accident: ☐ Work related ☐ Traffic ☐ Other Days missed work due to accident: _____

Date last worked: _____

WORK RELATED ACCIDENT

Employer: _____ Type of business: _____

Was an equipment, machinery and/or object related to accident? ☐ Yes ☐ No What kind? _____

Was accident reported to your employer? ☐ Yes ☐ No

Was a Worker's Comp claim filed? ☐ Yes ☐ No

List prior work related injuries: _____

Have you ever had a Worker's Compensation claim before? ☐ Yes ☐ No

TRAFFIC ACCIDENT

What kind of vehicle were you in when the accident occurred? ☐ Truck ☐ Car ☐ Motorcycle ☐ Other ☐ None

Were you a: ☐ Driver ☐ Passenger ☐ Pedestrian? Total number of people in the vehicle: _____

If a passenger, where were you seated in the vehicle? _____ What was the vehicle speed? _____ MPH

What part of the vehicle was hit? _____

Other vehicle hit? ☐ Yes ☐ No Where? _____

Was accident reported to police? ☐ Yes ☐ No Who received citations? _____

Have you been contacted by an insurance adjustor or company representative regarding this claim? ☐ Yes ☐ No

Name of your insurance adjustor: _____

Have you retained an attorney? ☐ Yes ☐ No Litigation? ☐ Yes ☐ No ☐ May be

If so, name and address: _____

GENERAL TRAFFIC OR WORK RELATED ACCIDENT INFORMATION

Describe accident including cause/s and surrounding circumstances: (Be Specific) _____

_____

_____

Any physical complaints prior to the accident? _____

What symptoms did you feel during the accident? _____

What symptoms were felt later in the day? _____

What symptoms did you feel the next day? _____

Since this injury, what are your symptoms? _____

Are you aware of any congenital problems or previous illness related to this injury? _____

How has this accident affected you either socially or emotionally? _____

If you consulted a doctor, give his/her name and diagnosis: _____ D.C. M.D. D.O. D.D.S.

Diagnosis: _____

What treatments did you receive? _____

Have you ever injured this area before? ☐ Yes ☐ No If so, when? _____

If injured before, did you lose time from work? ☐ Yes ☐ No

If you lost time from work with injuries, give name of doctor(s) consulted: _____

Have you ever been involved in any other type of accident, fall, or had a broken bone, etc.? Please give brief description.

_____

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/or forms to assist me in making any collections from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account. Upon receipt 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 be 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 to me will be immediately due and payable.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____ AG07C