Northwest Family
CHIROPRACTIC & MASSAGE

Accident Related Complaint

Was your complaint due to a: ☐ motor vehicle accident ☐ work related injury ☐ other
What was the date of your injury: _____

Motor Vehicle Accident (please complete if related to a car accident)

In your own words, please describe the accident: _____
_____
_____

Where you the: ☐ driver ☐ passenger
Where you in the: ☐front ☐ back ☐ drivers side ☐ passenger side
Was your vehicle hit from: ☐ front ☐behind ☐side
How many impacts were there: ☐ one ☐ two ☐ three ☐ other
Was the headrest positioned: ☐ at the level of the head ☐ below the head ☐ above the head
Where you wearing your seatbelt? ☐yes ☐no
Did the air bags deploy? ☐ yes ☐ no
Did you black out? ☐ yes ☐ no ☐ I don't know
Did you have your head turned? ☐ yes ☐ no ☐ I don't know
Did police come to the scene? ☐ yes ☐ no
Was a citation written? ☐ yes ☐ no If yes, to whom? _____
Did an ambulance come to the scene? ☐ yes ☐ no
Where you transferred to the hospital? ☐ yes ☐ no If yes, which one? _____
Have you seen any other provider? ☐ yes ☐ no
If yes, please list:
Name:_____ Phone # _____
Name: _____ Phone # _____
Name: _____ Phone # _____
Please list any other treatment/care you have had for this injury: _____
_____

Work Related Accident (please complete if related to a work injury)

In your own words, please describe the accident: _____
_____
_____

Have you reported this accident to your supervisor? ☐ yes ☐ no
Supervisors name: _____ Phone # _____
Have you ever injured yourself at work before? ☐ yes ☐ no If yes, when _____
Have you ever experienced this symptom before? ☐ yes ☐ no If yes, explain _____
Do you have an open claim for this work related injury? ☐ yes ☐ no
If yes, please provide information to our front desk assistant.
Have you seen any other provider? ☐ yes ☐ no
If yes, please list:
Name:_____ Phone # _____
Name: _____ Phone # _____
Name: _____ Phone # _____
Please list any other treatment/care you have had for this injury: _____
_____