Auto Accident/Personal Injury Form

Date ____/____/____ Date of Accident: ____/____/____ Referred By:_____

Name: _____ SS#:_____-_____- _____

Address: _____ City: _____ ST:_____ Zip:_____

Home Phone#: _____ Cell#: _____ Work#:_____

Date of Birth: _____ Age:_____ Marital Status: _____ Number of Children:_____

Occupation: _____ Email:_____

Employer: _____ Address:_____

Your Auto Insurance:_____ Address: _____

Your Auto Insurance Agent: _____ Phone#:_____

Claim#:_____

Responsible Party:_____

Their Insurance Company:_____ Address:_____

Contact Person:_____ Phone & Fax:_____

Claim#: _____

Attorney if applicable:_____ Phone:_____

Attorney Address:_____

Your Health Insurance: _____ Policy# _____

Policy Holders Name: _____ Employer: _____

When was the last time you saw a Chiropractor? _____ For what: _____

Nature of the Accident

Time of day the accident occurred: _____ Weather:_____

Location of accident:_____

You were: ____driver ____passenger front ____ passenger back ____ other ____ had seat belt on

Number of people in the car:_____

You were struck from the: _____front ____ rear ____ right side ____left side

You struck another on the: _____front _____rear ____ right side ____ left side

On impact were you jarred about? ____ yes ___ no

Did you strike anything in the vehicle? ____ yes ____ no; please specify _____

Did you require immediate medical attention at the scene? ____ yes ___no for what:_____

Did you go to an emergency room? ____ yes ____ no By ambulance? ____ yes ____ no

Which Hospital? _____

What was done to you at the Hospital? _____

Any medications prescribed? ____ yes ____ no If so, what? _____

Please describe how you felt immediately after the accident: _____

_____

A few hours later / that night _____

The next day _____

How is your sleep quality? _____

Have you been treated by any other physicians since the accident? ____ yes ____ no

If so, who and for what?_____

What type of treatment? _____

What are your present symptoms? _____

What gives you relief? _____

What makes you worse?_____

Are your symptoms worse at a particular time of day? _____ yes ____ no If so, what time of day? _____

Does position / movement affect your symptom? ___ yes ___ no If so, what movement?_____

On a scale of 0-10 with 0 being no pain and 10 being the worst pain you have ever experienced,

your pain now_____ on average _____ in the morning _____

at night _____ at it's worst____ at it's best _____

Since the accident have your symptoms:_____ improved ____ getting better ____getting worse ___same

Have you lost any time from work because of the accident? ___ yes ___no If yes, how long_____

Did you have any physical symptoms before the accident? ____ yes ___ no

If yes, what where they? _____

Have you had any other accidents prior to this? ____ yes ____ no

If yes, how long ago and any injuries (list)?_____

Were there any permanent impairments issued? ____ yes ____no

If yes, what was the rating and for what area/body parts? _____

If you are a female, is there a possibility that you may be pregnant? ____ yes ____no

Do you smoke? ____yes ____no If yes, how much in a day?_____

Do you consume alcohol daily? ____yes ____no, If yes, how much and what type? _____

Do you exercise regularly? ____yes ____no If yes, what and how often?_____

Do you have any medical conditions for which you treat/consult with another physician? ___yes ___no

If so, who and for what? _____

_____Phone#_____

What is the treatment/medication? _____

Who is your Primary Care Doctor?_____Phone#_____

Have you had any surgery or ever been in the hospital? ___yes ____no

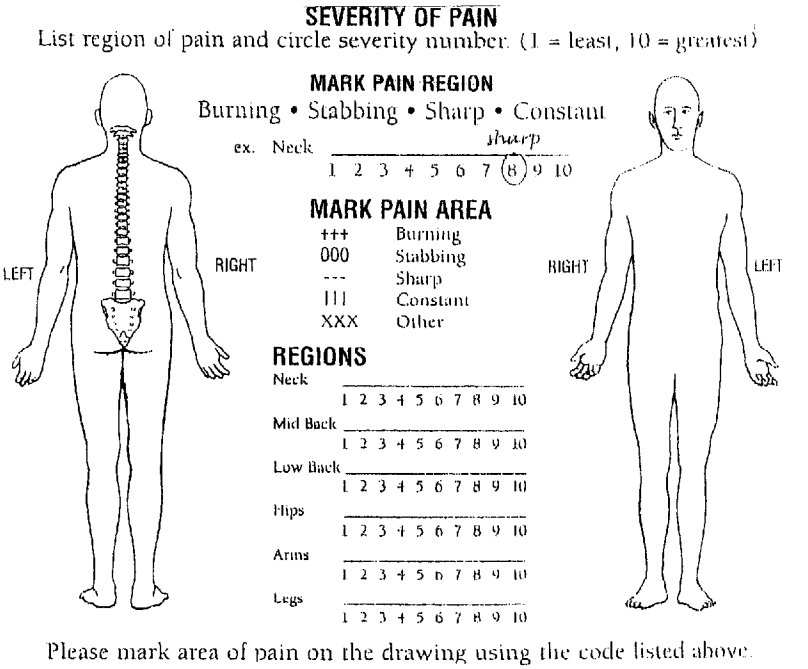
If so, for what and when _____

Other pertinent information_____

_____

Please circle the symptoms you have noticed since the accident:

headaches	irritability	numbness in the toes	shoulder pain	neck pain
chest pain	knee pain	shortness of breath	neck stiff	dizziness
fatigue	jaw pain	sleeping problems	depression	buzzing in the ears
back pain	nervousness	head seems heavy	fainting	pins and needles in arm
tension	stomach upset	numbness in fingers	ears ring	pins and needles in legs
hands cold	feet cold	numbness in toes	loss of memory	light bothers eyes
loss of balance	blurred vision			



What is your goal from care in this office? ____ temporary relief ____ maximum correction

I understand and agree that health and accident insurance policies are an arrangement between an insurance company an myself. Furthermore, I understand that the doctor in this office (Dr. Gina M. Carucci and Associates at Carucci Chiropractic Center, LLC) will prepare any necessary reports and forms to assist me in making collections from the insurance companys. However, ***I CLEARLY,*** understand and agree that all services rendered me are charged directly to me and that I am personally responsible for any unpaid balance.

_____

Patient's Signature Date

_____

Signature of parent/guardian if a minor Date

_____

Office personal witness Date