CARBONE CHIROPRACTIC CENTER, LLC

Auto Accident/Personal Injury Form

TODAY'S DATE: _____ REFERRED BY:_____ FILE #

NAME: _____ SOCIAL SECURITY # _____

ADDRESS: _____ CITY:_____ STATE_____ ZIP _____

H ( )_____ C ( )_____ W ( )_____

BIRTH DATE: _____ AGE: _____

YOUR AUTO INSURANCE:_____ ADDRESS:_____

CLAIM #_____

RESPONSIBLE PARTY:_____

INSURANCE COMPANY:_____ ADDRESS:_____

CONTACT PERSON:_____ PHONE:_____ FAX:_____

ATTORNEY IF APPLICABLE:_____ PHONE:_____ FAX:_____

ATTORNEY'S ADDRESS:_____

HEALTH INSURANCE:_____ POLICY NUMBER:_____

POLICY HOLDERS NAME: _____ EMPLOYER:_____

HEALTH INS. ADDRESS:_____

NATURE OF THE ACCIDENT

DATE OF ACCIDENT:_____ TIME OF DAY:_____ LOCATION:_____

YOU WERE: DRIVER PASSENGER IN FRONT PASSENGER IN BACK OTHER WORE SEAT BELT

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 THE EMERGENCY ROOM? ___YES ___NO BY AMBULANCE? ___YES ___NO

WHAT HOSPITAL?_____

WHAT WAS DONE TO YOU AT THE HOSPITAL? _____

ANY MEDICATION PRESCRIBED? ___YES ___NO IF SO, WHAT? _____

_____

PLEASE DESCRIBE HOW YOU FELT IMMEDIATELY AFTER THE ACCIDENT: _____

_____

HOW DID YOU FEEL A FEW HOURS LATER/THAT NIGHT: _____

HOW DID YOU FEEL THE NEXT DAY:_____

HOW IS YOUR SLEEP QUALITY? _____

HAVE YOU BEEN TREATED BY ANY OTHER PHYSICIANS SINCE THE ACCIDENT? ___YES ___NO IF SO, FOR WHAT:_____

_____

WHAT ARE YOUR PRESENT SYMPTOMS?_____

WHAT GIVE YOU RELIEF? _____

WHAT MAKES YOU WORSE?_____

DOES THE TIME OF DAY AFFECT YOUR SYMPTOMS?_____

DOES POSITION/MOVEMENT AFFECT YOUR SYMPTOMS?_____

ON A SCALE OF 0-10 WITH 0 BEING NO PAIN AND 10 BEING THE WORST PAIN YOU HAVE EVER EXPERIENCED, RATE YOUR PAIN:

NOW _____, ON AVERAGE _____, IN THE MORNING _____, AT NIGHT_____, AT ITS WORSE_____ AT ITS BEST_____

SINCE THE ACCIDENT HAVE YOUR SYMPTOMS: ___IMPROVED, ___GETTING BETTER, _____GETTING WORSE, _____THE 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 WERE THEY: _____

_____

HAVE YOU HAD ANY OTHER ACCIDENTS PRIOR TO THIS? ___YES ___NO IF YES, WHEN AND WHAT WERE YOUR INJURIES? _____

_____

WERE THERE ANY PERMANENT IMPAIRMENTS ISSUED? ___YES ___ NO IF YES, WHAT WAS THE RATING AND FOR WHAT AREA/BODY PART(S)?_____

DO YOU HAVE ANY MEDICAL CONDITIONS FOR WHICH YOU TREAT/CONSULT WITH ANOTHER PHYSICIAN? ___YES ___NO
IF YES, WHO AND FOR WHAT AND WHAT IS THE TREATMENT? _____
_____

PLEASE CIRCLE THE SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

HEADACHES	NECK PAIN	UPPER BACK	MID BACK PAIN
LOW BACK PAIN	WRIST/HAND PAIN	HIP PAIN	KNEE PAIN
ELBOW PAIN	ANKLE/FOOT PAIN	SHOULDER PAIN	CHEST PAIN
JAW PAIN	RINGING IN EARS	BUZZING IN EARS	IRRITABILITY
TENSION	DIZZINESS	SHORTNESS OF BREATH	STIFF NECK
FATIGUE	SLEEPING PROBLEMS	DEPRESSION	NERVOUSNESS
HEAD SEEMS HEAVY	FAINTING	UPSET STOMACH	BLURRED VISION
PINS/NEEDLES IN LEGS	PINS/NEEDLES IN ARMS	NUMBNESS IN FINGERS	NUMBNESS IN TOES
COLD HANDS	COLD FEET	LOSS OF BALANCE	LOSS OF MEMORY

I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN THE INSURANCE COMPANY AND MYSELF. FURTHERMORE, I UNDERSTAND THAT THE DOCTOR'S IN THIS OFFICE (CARBONE, CHIROPRACTIC CENTER, LCC) WILL PREPARE ANY NECESSARY REPORTS AND FORMS TO ASSIST ME IN MAKING COLLECTIONS FROM THE INSURANCE COMPANY. 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.

_____ _____

SIGNATURE OF PATIENT OR GUARDIAN IF A MINOR DATE