Patient Automobile Accident Form

NORTHLAKE CHIROPRACTIC

Today's Date: _____ Patient #:_____

Last Name:_____ First Name:_____ SSN:_____

Address:_____ DOB:_____

City:_____ State:_____ Zip:_____ Gender: M or F

Home Phone:_____ Work/Cell Phone:_____ Email:_____

Marital Status:_____ Spouses Name:_____ Employer:_____

Referred by:_____ Occupation:_____

Your Insurance Company: _____

Claims address:_____ Phone #:_____

Effective Date:_____ Policy #:_____ Group #:_____

Vehicle Driver:_____

There Insurance Company: _____

Claims address:_____ Phone #:_____

Effective Date:_____ Policy #:_____ Group #:_____

Relationship to Insured:_____

GIve the time and date present accident occurred _____ AM PM ____/____/____
Please explain in detail how the accident occurred:

_____

_____

What direction where you heading? _____ The other vehicle heading? _____
Did you strike the windshield or object? Yes No Did you loose consciousness? Yes No If so, how long? _____
You were struck from? Front Behind Left side Right side Seat belt on? Yes No
Number of people in the car _____ Your position in the car _____
Were you taken to the hospital after the accident? Yes No What treatment did you receive? _____
If so, give doctors name _____ Phone Number _____
Doctors diagnosis _____
Did you feel pain immediately after the accident? Yes No ___ later that day ___Next day When? _____
What were the symptoms you experienced? _____
Did you ever have complaints in the involved area before? Yes No If so, when? _____
If so, were they due to ____ previous car accident or _____ on the job injury?
Before the injury, were you capable of working on an equal basis with others your age? Yes No
Are your work activities/activities of daily living restricted as a result of this accident? Yes No
Since the injury, are your symptoms ___ Improving? ___Getting worse? ___ The same?
Have you retained an attorney? Yes No Name _____ Phone number _____

Rate your pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (extreme pain)

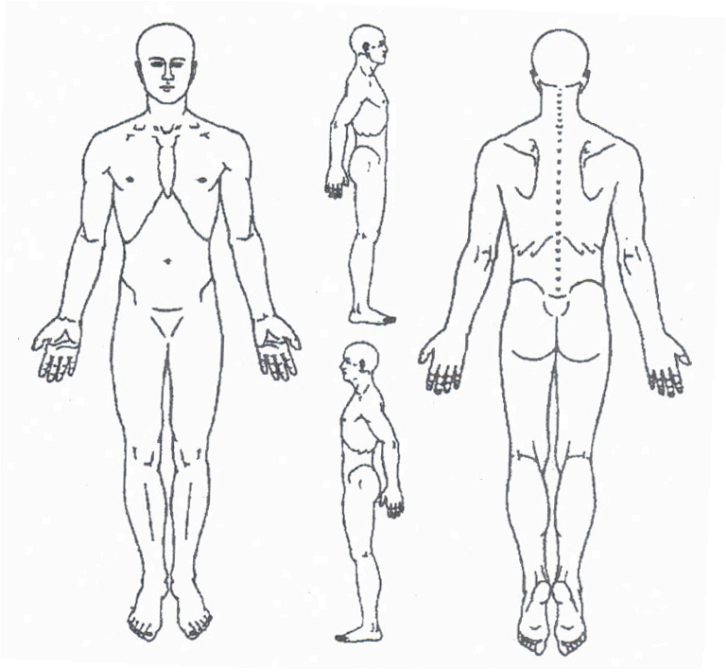
What aggravates your condition(s): ☐ Standing ☐ Twisting ☐ Bending ☐ Sitting ☐ Lying ☐ Walking ☐ Coughing ☐ Lifting

Areas of injury or discomfort:

On the following chart mark area(s) of injury or discomfort.
Mark all the areas with the appropriate symbols and indicate the degree of pain on a scale from 1 (minimal) to 10 (extreme).

NNNN	Numbness
PPPP	Pins & Needles
BBBB	Burning
AAAA	Aching
SSSS	Stabbing

Circle any area of pain not represented by a symbol.



Are your symptoms:
___ Improving
___ About the same
___ Getting worse
___ Intermittent (comes and goes)

Have you had these symptoms before? No Yes

Past Health History

Major Surgeries: _____
Hospitalizations: _____
Accidents or falls: _____
List all prescription drugs you now take: _____
List all NON-prescription drugs you now take: _____

Please check any of the following that you currently have or have had in the past:

__ Headaches	__ Bronchitis	__ Hiatal Hernia	__ Thyroid Problems
__ Sinus/Allergies	__ Pulmonary Disease	__ Premenstrual Pains	__ Fatigue
__ Asthma	__ Emphysema	__ Joint Pain	__ Depression
__ High Blood Pressure	__ Pneumonia	__ Jaw Pain	__ Chest Pains
__ Low blood pressure	__ Kidney Stones	__ Shoulder Pain	__ Stomach Problems
__ Heart Disease	__ Gastric Ulcers	__ Numbness	__ Arthritis
__ Heart Murmurs	__ Colitis/Spastic Colon	__ Hepatitis A, B, C	__ Sciatica/Buttock Pain
__ Diabetes	__ Acid Reflux	__ HIV/AIDS	__ Dizziness
__ Difficult/Painful Urination	__ ADD/ADHD	__ Fractures	__ Skin Problems

I hereby authorize Dr. Leslie Mosbey and the staff of Northlake Chiropractic to administer any treatments and testing necessary for the purpose of improving my physical condition. The above patient information is true and accurate to the best of my knowledge.

_____ _____ _____

Patient Signature (custodial parent or legal guardian if patient is a minor) Relationship to patient Date