FIDEL CHIROPRACTIC CENTER (PLEASE PRINT)

PATIENT NAME ______________________ WORK NUMBER (   ) _____ - _______
HOME NUMBER (   ) _____ - _______
CELL NUMBER (   ) _____ - _______

Address ______________________

City ______________________ State __________ Zip __________

BIRTHDATE ______________ SS#: _____ - _____ - _____

AGE __________ HEIGHT __________ WEIGHT ________ lbs.

E-mail ______________________

Primary care physician: ______________________

How did you hear about our office? ______________________

Occupation ______________________

Employer ______________________

Have you missed work, as a result of this accident? ( )Yes ( ) No

If Yes, Full time off work from to ______

Part time off work from to ______

Name of spouse ______________ Work number ______________ Spouse's

Occupation ______________ Employer ______________

In the event of an emergency, whom should we contact? ______________

Phone number (____) ______ - ________

AUTOMOBILE ACCIDENT-INSURANCE DATA

Date Of Accident: ______________

1. PATIENT'S INSURANCE COMPANY INFORMATION:

Company Name ______________ Phone ______________ Policy __________

Address ______________ Adjuster ______________

City ______________ State ______________ Zip __________

CLAIM#: ______________

2. INSURED'S INSURANCE INFORMATION:

Insured's Name **(if other than patient)** ______________ Comp

Name ______________ Phone ______________ Policy __________

Address ______________ Adjuster ______________

City ______________ State ______________ Zip __________

CLAIM#: ______________

3. OTHER DRIVER'S INSURANCE INFORMATION:

Other Driver's Name **(if another car was involved)** ______________

Company Name ______________ Phone ______________ Policy __________

Address ______________ Adjuster ______________

City ______________ State ______________ Zip __________

CLAIM#: ______________

4. PATIENT'S HEALTH INSURANCE:

Name of insured ______________ Employer of insured ______________

Insurance company ______________ Policy # ______________

Address ______________ Phone # ______________

Do you have an attorney on this case? ( )No ( )Yes

Name ______________________________

Address ______________________________

City ______________________ State ________ Zip ________

Phone ______________________

DATE OF ACCIDENT: _________ TIME:_________( )AM ( )PM

DRIVER OF CAR ______________________ WHERE WERE YOU SEATED? ____________

WHO OWNS THE CAR? ______________________ YEAR & MODEL OF CAR ____________

WHAT WAS THE APPROXIMATE DAMAGE DONE TO THE CAR? $______________

Describe in your own words how the accident occurred: ______________________

____

Where was your car struck? Right / Left / Front / Side / Rear:______________________

Type of accident: ( )Head-on ( )Broad-sided ( )Front impact, rear-ended car in front ( )Rear-end ( )Non-collision

Did you see the accident coming? ( )Yes ( )No

Did you brace for the impact: ( )Yes ( )No

Were seat belts worn? ( )Yes ( )No

Were shoulder harnesses worn? ( )Yes ( )No

Does your car have headrests? ( )Yes ( )No

If yes, what was the position of those headrests compared to your head before the accident?

( ) Top of headrest even with bottom of head.

( ) Top of headrest even with top of head.

( ) Top of headrest even with middle of neck.

Was your car braking? ( ) Yes ( ) No

How fast would you estimate you were going? ______________ m.p.h.

How fast was the other car traveling?________m.p.h.(estimate)

Head/Body Position at time of impact:

( )head turned right/left ( )body rotated right/left

( )head looking back ( )body straight in sitting

( )head straight forward position.

Upon impact, what happened to your head or body within the car? ______________________

As a result of the accident, you were:

( ) rendered unconscious ( ) dazed, circumstances vague

( ) shaken up but could function ( ) other:

Could you move all parts of your body? ( ) Yes ( ) No

If no, what parts and why?______________________

Were you able to get out of the car and walk unaided? ( ) Yes ( ) No

If no, why not? ______________________ Did you get bleeding cuts or bruises? ( ) Yes ( )No

If yes, Describe: ______________________

Please describe how you felt. (Please be specific)

Immediately after the accident:______________________

Later that day:______________________

The next day: ______________________

Did you seek medical help immediately or soon after the accident? ( )Yes ( )No
If yes, how did you get there? ( ) Ambulance ( ) Someone else drove me ( ) Drove own car ( ) Police

DOCTOR 1/HOSPITAL/CLINIC SEEN:__________ Date of 1st visit __________
Were you examined? ( )Yes ( )No Were X-ray taken? ( )Yes ( )No Were you given treatment? ( ) Yes ( ) No
If yes, what treatment was given to you? __________
What benefits did you receive from the treatment? __________
Date of last treatment: __________

DOCTOR 2/CLINIC SEEN: __________ Date of 1st visit __________
Were you examined? ( )Yes ( )No Were X-ray taken? ( )Yes ( )No Were you given treatment? ( ) Yes ( )No
If yes, what treatment was given to you? __________
What benefits did you receive from the treatment? __________
Date of last treatment: __________

List other doctors that you have seen related to this accident. __________

DESCRIBE YOUR CURRENT COMPLAINTS: (please be specific) __________

What activities make condition worse? __________
What activities make condition better? __________

-On a scale of 1-10, with 1 being, "I am pain free and can function quite well," and 10 being " I am in pain all the time and cannot function at all," rate yourself? 1 2 3 4 5 6 7 8 9 10.

Please explain why: __________

(WOMEN ONLY) Are you pregnant? ( )Yes ( )No Date of onset of last menstrual cycle: __________

Check symptoms apparent since the accident:

( )Headaches
( )Neck pain
( )Mid back pain
( )Low back pain
( )Tension
( )Pain behind eyes
( )Dizziness
( )Fainting
( )Sleeping problem
( )Loss of balance
( )Loss of smell
( )Loss of taste
( )Loss of memory
( )Fatigue
( )Constipation
( )Chest pain
( )Irritability
( )Depression
( )Anxious
( )Numbness in toes
( )Numbness in fingers
( )Cold hands
( )Cold feet
( )Diarrhea
( )Eyes light sensitive
( )Loss of breath
( )Nervousness
( )Cold Sweats
( )Ringing/buzzing ears
( )Other:

Did you have any physical complaints JUST BEFORE THE ACCIDENT? ( ) Yes ( )No
If yes, please describe in detail: __________
PRIOR to this accident, have you EVER had symptoms similar to what you are experiencing now? ( ) Yes ( ) No
If yes, please explain __________

MY SIGNATURE IS ACKNOWLEDGEMENT THAT THE ABOVE STATEMENTS ARE TRUE.

PATIENT SIGNATURE X__________ TODAY'S DATE: __________
Witness __________