SEAHURST CHIROPRACTIC CLINIC | AUTO ACCIDENT/WORK/PERSONAL INJURY INFORMATION

AUTO ACCIDENT OR PERSONAL INJURY

Please complete the following information regarding when & where the accident occurred:

Date: _____ Time: _____ ☐ a.m. ☐ p.m.

Location - Intersection/Street: _____

City: _____ State: _____

Were you the: ☐ Driver ☐ Front passenger ☐ Rear Passenger

Your Vehicle: Make _____ Model _____

Your approximate speed before the collision: _____ mph

Traffic violation issued: ☐ Yes ☐ No To whom: _____

Did police arrive at the accident site? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

What did you impact? ☐ Vehicle ☐ Other If Other, please explain:

_____

_____

Did any part of your body strike anything in the vehicle? ☐ Yes ☐ No

If Yes, please describe: _____

_____

The impact to your vehicle came from which direction:

☐ Front ☐ Rear ☐ Right Side ☐ Left Side ☐ Other

During impact, were you facing: ☐ Right ☐ Left ☐ Forward

At time of impact, were you: ☐ Aware ☐ Unaware

If you made impact with another vehicle, provide the following:

Other Vehicle: Make _____ Model _____

Other vehicle approximate speed: _____ mph

In your own words, please describe the accident: _____

_____

_____

WORK RELATED ACCIDENT

Please complete the following information regarding when & where the accident occurred:

Date: _____ Time: _____ ☐ a.m. ☐ p.m.

Location - Complete address: _____

City: _____ State: _____

Was your accident directly related to your work? ☐ Yes ☐ No

Briefly describe the events that occurred just **before and during** your accident: _____

_____

Did you report your accident to your employer? ☐ Yes ☐ No

What recommendations did your employer make right after the accident? _____

_____

Has this type of accident happened to you before?

☐ Yes ☐ No ☐ Unsure

INSURANCE/CLAIM FILING INFORMATION

Insurance Name (PIP): _____

Agent/Adjuster's Name: _____

Telephone #: _____ - _____ - _____

Address: _____

City: _____ State: _____ Zip Code: _____

Insurer's Name: _____

Policy #: _____ Claim #: _____

Third Party's Name: _____

Third Party's Insurance Name: _____

Agent/Adjuster Name: _____

Agent/Adjuster Telephone #: _____ - _____ - _____

AUTO ACCIDENT/WORK/PERSONAL INJURY INFORMATION

Did the accident render you unconscious? ☐ Yes ☐ No
If yes, for how long? _____
Please describe how you felt immediately after the accident:
_____

Did you go to the hospital, or have you seen a doctor? ☐ Yes ☐ No
When did you go? ☐ Just after accident ☐ The next day ☐ 2 days plus
How did you get there? ☐ Ambulance ☐ Private Transportation
What hospital? _____
What doctor? _____
Describe any treatment you received:
_____

X-Rays: ☐ None taken Please list the areas of the body that were x-rayed:
_____

Any medications prescribed? ☐ Yes ☐ No Please list medications:
_____

Have you been able to work since this injury? ☐ Yes ☐ No
Are your work activities restricted as a result of this injury? ☐ Yes ☐ No
Please indicate the symptoms that are a result of your accident:

___ Arms/Shoulder Pain	___ Difficulty Sleeping	___ Jaw Problems	___ Neck Stiffness
___ Back Pain	___ Dizziness	___ Leg Pain	___ Numb Feet/Toes
___ Back Stiffness	___ Ears Ringing	___ Lower Back Pain	___ Numb Hands/Fingers
___ Blurred Vision	___ Fatigue	___ Memory Loss	___ Shortness of Breath
___ Buzzing in Ears	___ Headache(s)	___ Nausea	___ Stomach Upset
___ Chest Pain	___ Irritability	___ Neck Pain	___ Tension

___ Other: _____

Is your condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes & Goes
Have you retained an attorney? ☐ Yes ☐ No
Attorney Name: _____
Telephone #: _____ - _____ - _____

Indicate your degree of comfort when performing these activities:

	COMFORTABLE	UNCOMFORTABLE	PAINFUL
Bending	____	____	____
Kneeling	____	____	____
Lifting	____	____	____
Lovemaking	____	____	____
Lying on Back	____	____	____
Lying on Side	____	____	____
Lying on stomach	____	____	____
Pulling	____	____	____
Reaching	____	____	____
Running	____	____	____
Sitting	____	____	____
Sports	____	____	____
Standing	____	____	____
Stretching	____	____	____
Walking	____	____	____
Working	____	____	____

How many hours are in your normal work day? _____ hrs.
Please indicate your daily job duties & any activities you occasionally perform:

___ Bending	___ Operating equipment	___ Twisting
___ Crawling	___ Sitting	___ Typing
___ Driving	___ Standing	___ Walking
___ Lifting	___ Stooping	___ Work w/arms above head

___ Other _____

Prior to injury, were you capable of working on an equal basis w/ your peers? ☐ Yes ☐ No
What positions can you work in w/minimum physical effort?
_____

For how long? _____ ☐ N/A
Do you work w/others who can assist w/ any heavy lifting? ☐ Yes ☐ No
While in recovery, could you request any light duty? ☐ Yes ☐ No

Please inform us if any of your health or account information has changed. PLEASE UNDERSTAND THAT ANY BALANCE ON THIS ACCOUNT IS ULTIMATELY YOUR RESPONSIBILITY. Any outstanding balance unpaid by the insurance and/or attorney is due immediately upon settlement.

Signature: _____ Date: _____
Patient's Name: _____ SCC Witness: _____