HART FAMILY CHIROPRACTIC

IF YOURS IS AN ACCIDENTAL INJURY PLEASE COMPLETE THE FOLLOWING QUESTIONS

Name _____ Address _____

Date of Accident _____ Hour _____ A.M. _____ P.M. Location _____

How Did Accident Occur? ☐ Auto Collision ☐ On-the-job injury ☐ Other _____

If Not An Auto Collision, Please Describe The Circumstances _____

_____

_____

Did You Report the Injury to your Foreman or Employer? ☐ Yes ☐ No

Did He (They) Recommend Care at Our Office? ☐ Yes ☐ No

If Auto Accident, Were You Driver ☐ Passenger ☐ Pedestrian ☐

If Auto Collision Were You Struck From Behind ☐ Right Side ☐ Left Side ☐ Front ☐ Auto Was Parked ☐

Did Your Car Strike The Other(s) Involved? ☐ YES ☐ NO;

Or Did The Other Car Strike Yours? ☐ YES ☐ NO ☐ Undetermined

As a Result of the Accident, Were Traffic Citations Issued to You? ☐ YES ☐ NO;

To the Driver of the Other Car ☐ YES ☐ NO;

To the Driver of Your Car ☐ YES ☐ NO

List the Extent of the Injuries as You Know Them _____

_____

_____

Did You Require Post-Accident Hospitalization ☐ YES ☐ NO

CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT

☐ Headache	☐ Irritability	☐ Numbness in Toes	☐ Face Flushed	☐ Feet Cold
☐ Neck Pain	☐ Chest Pain	☐ Shortness of Breath	☐ Buzzing in Ears	☐ Hands Cold
☐ Sleeping Problems	☐ Head Seems Too Heavy	☐ Depression	☐ Fainting	☐ Constipation
☐ Back Pain	☐ Pins & Needles in Arms	☐ Lights Bother Eyes	☐ Loss of Smell	☐ Cold Sweats
☐ Nervousness	☐ Pins & Needles in Legs	☐ Loss of Memory	☐ Loss of Taste	☐ Fever
☐ Tension	☐ Numbness in Fingers	☐ Ears Ring	☐ Diarrhea	☐ _____

Symptoms Other Than Above _____

Have You Lost Any Days of Work? _____ Dates _____

Insurance Companies Involved:

My Company _____

Company of Person Responsible for Injuries _____

Have You Been Contacted by an Insurance Adjuster or Company Representative Regarding this Cliam ☐ YES ☐ NO.

Do You Have an Attorney that Has Advised You in This Case ☐ YES ☐ NO

Attorney's Name _____ Address _____ Telephone _____

★ Car Accident — Over Please