

Needham Family Chiropractic
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Name of the Patient: _____

Home Address: _____

Phone: _____

Vehicular Accident

IF YOURS IS A VEHICULAR ACCIDENTAL INJURY, COMPLETE THE FOLLOWING

Submission Date: _____ Date of Accident: _____ Hour: __ AM __ PM ____

Location: _____

How did the accident occur? ____ Auto Collision ____ On-the -job-Injury ____ Other

Please describe the circumstances: _____

If vehicle accident, you were: __ Driver? ____ Passenger? ____ Pedestrian?

If vehicle collision, you were struck from: __ Behind? __ Right Side? __ Left Side? __ Front? __ Auto was parked?

Did your vehicle strike the other(s) involved? ____ Yes ____ No

Was traffic citation issued to you? ____ Yes ____ No

Was traffic citation issued to driver of other vehicle? ____ Yes ____ No

List the extent of the injuries as known: _____

CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT

- | | | | |
|---------------------------------------|---|--|---|
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Pins/Needles |
| <input type="checkbox"/> Buzzing Ears | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Pins/Needles in Arms |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Feet Cold | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Sleeping Problems |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Hands Cold | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Head Seems Heavy | <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Headache | <input type="checkbox"/> Nervousness | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Irritability | <input type="checkbox"/> Numb in Fingers | |
| <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Light bothers eyes | <input type="checkbox"/> Numb in Toes | |

Symptoms other than above: _____

Have you lost any days of work? ____ Yes ____ No Dates: _____

Name of your Insurance Company involved: _____

Name of Insurance Company of person responsible for injuries: _____

If you have an Insurance Adjuster, fill in Name, Phone and Claim #. If you do not have, type "NO"

Do you have an attorney who has advised you in this case? ____ Yes ____ No

Attorney Name: _____ Phone Number: _____

Address: _____