Date_____ Dr._____ Patient_____ #_____

REPORT OF ACCIDENT OR INJURY Date of Accident_____ Time of day_____

Where was injury sustained? Auto_____ Work _____ Other_____

How did accident occur?_____

_____

Describe in detail all of your complaints and injuries:_____

_____

_____

Have you consulted any other physicians for this injury? Yes_____ No_____

If yes, Doctor's Name and Address:_____

Do you have an Attorney representing you in this case? Yes_____ No_____

If yes, Attorney's Name and Address:_____

****

ACCIDENTS

Who was responsible for this accident?_____

Your Insurance (Auto or Other)	Other Party's Insurance
Insured's Name:_____	Insured's Name:_____
Policy#:_____	Policy#:_____
Claim#:_____	Claim#:_____
Name and Address of Insurance Company:	Name and Address of Insurance Company:
_____	_____
_____	_____
_____	_____
Are claim forms required?_____	Are claim forms required?_____

****

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the ARLINGTON CHIROPRACTIC CLINIC to release any information acquired in the course of my examination and/or treatment.

_____
Patient Signature (Parent if a minor)

Date_____ Dr._____ Pt._____ #_____

PATIENT COMPLAINTS
(answer all questions completely)

1. Have you been hurt or injured in an accident? ☐ Yes ☐ No

   Did you experience loss of consciousness? ☐ Yes ☐ No

2. Check type of accident:
   a. Passenger in automobile _____ Where?_____
   b. Driver of automobile_____ Seat belts? ☐ Yes ☐ No
   c. Pedestrian struck by car_____
   d. Slipped (or tripped) and fell_____
   e. Other: Please describe_____
   _____

3. Please check which parts of your body hurt or bother you:
   a. HEAD:
      Eyes_____ Forehead_____
      Nose_____ Chin_____
      Mouth_____ Top of head_____
      Teeth_____ Right side of head_____
      Ears_____ Left side of head_____
      Scalp_____ Back of head_____
      Cheeks_____ Other: (please describe)_____
      _____
   b. NECK:
      Front_____ Right side_____
      Back_____ Left side_____
   c. BACK:
      Upper_____ Right side_____
      Middle_____ Left side_____
      Lower_____ Other: (please describe)_____
      _____
   d. SHOULDER:
      Right_____ Left_____
   e. RIGHT ARM:
      Elbow_____ Between shoulder & elbow_____
      Wrist_____ Between elbow & wrist_____
      Hand & Fingers_____ Other: (please describe)_____
      _____
   f. LEFT ARM:
      Elbow_____ Between shoulder & elbow_____
      Wrist_____ Between elbow & wrist_____
      Hand & Fingers_____ Other: (please describe)_____
      _____
   g. CHEST
      Right side_____ Upper_____
      Left side_____ Lower_____
   h. ABDOMEN AND STOMACH:_____
   i. GENITALS:_____

j. RIGHT LEG:

Right knee_____ Between hip & left knee_____
Right ankle_____ Between right knee & ankle_____
Right buttocks_____ Right foot or toes_____

k. LEFT LEG:

Left knee_____ Between hip & left knee_____
Left ankle_____ Between left knee & ankle_____
Left buttocks_____ Left foot or toes_____

4. Since your accident or injury, have you had any of the following problems?

a. Nervousness_____ h. Numbness_____
b. Blurred vision_____ i. Urinary difficulty or lost control
c. Change in bowel habits_____ _____
d. Nausea, vomiting_____ j. Loss of appetite_____
e. Pain on breathing, moving____ k. Dizziness/fainting_____
f. Difficulty sleeping_____ l. Depression_____
g. Pain on swallowing_____ m. Other: (please describe)_____
_____

5. To what body parts have you received trauma (bumped) or bruises?

_____

6. Have you been seen by any other physician, clinic or hospital for this injury? ☐ Yes ☐ No
If yes, describe:_____

What tests were done?_____

Medications prescribed?_____

Other treatment?_____

7. Have you been unable to work since the injury? ☐ No

☐ Yes _____

8. Have you been unable to perform daily activities? ☐ No

☐ Yes Describe_____

9 Have you been involved in any accidents or injuries in the past?
Describe type and dates:_____

_____

10. Mark your areas of pain or problems: