Life Care Chiropractic & Wellness Center

Personal Injury History

Patients Name _____ Date _____

Insurance Company Name _____ Claim # _____

Car Insurance Policy Holder _____ Policy # _____

Insurance Company Address _____

Your Insurance Policy Holder _____ Policy # _____

Insurance Company Name _____ Claim# _____

Insurance Company Address _____

ATTORNEY

Name _____ Phone _____

Address _____

HISTORY OF THE ACCIDENT

1. Date of accident _____ Time _____ AM/PM
2. Were you: ☐ Driver ☐ Passenger ☐ Front Seat ☐ Back Seat ☐ Right Side ☐ Left Side
3. How far is the top of the headrest or seat back from the top of your head? _____
4. Number of people in the vehicle _____
5. The following safety devices were used: ☐ Lap seat belt ☐ Shoulder strap seat belt ☐ Airbag

Did you receive a bruise or injury from above safety devices? _____ If yes, explain_____

_____

6. What direction were you looking? ☐ forward ☐ right ☐ left ☐ over shoulder
7. Was your body facing forward? ☐ Yes ☐ No If no, explain _____
8. Street of accident _____ City/ State _____
9. Make and model of your car _____ Of their car _____
10. Estimated damage to your vehicle _____
11. Initial Impact to your car ☐ Front ☐ Back ☐ Right Side ☐ Left Side

Was there a second impact? ☐ Yes ☐ No If yes, where _____

12. At the time of impact were you ☐ Stopped, if stopped was foot on brake? ☐ Yes ☐ No
    ☐ Slowing down ☐ Gaining Speed ☐ Steady Speed
13. Approximate speed of your car _____ other car _____
14. Prior to impact were you aware of approaching collision: ☐ Aware ☐ Surprised
15. Road conditions at time of impact: ☐ Wet ☐ Dry ☐ Icy ☐ Other _____

16. On what part of the auto did you experience impact with the following body parts?

Head_____ Rt/Lt Knee_____ Rt/Lt Shoulder _____

Chest_____ Rt/Lt Leg _____ Other_____

Rt/Lt Hip_____ Rt/Lt Arm _____ Other_____

17. Did you receive bleeding cuts? ☐ Yes ☐ No Bruises? ☐ Yes ☐ No

Describe_____

18. Which of the following car parts broke? ☐ Windshield ☐ Rt/Lt Window ☐ Steering Wheel ☐ Front Seat ☐ Other_____

19. Were the police at the scene? ☐ Yes ☐ No Police Report # _____

20. Where did you go directly following the accident? ☐ Home ☐ Work ☐ Hospital ☐ Other_____

Name & city of hospital _____ Date _____ Time_____

Were you admitted? ☐ Yes ☐ No If yes, date of release from hospital _____

Please describe the treatment you received _____

_____

21. Which of the following diagnostic procedures were performed? By whom? When?

☐ Xrays _____ ☐ CT Scan _____

☐ MRI _____ ☐ EEG _____

☐ Other _____

22. Have you seen other health care providers for your injuries? ☐ Yes ☐ No

Provide Dr's. Name/City _____

23. Are you still under care with any other provider for the injuries? ☐ Yes ☐ No

If yes, by whom _____

24. In your own words and to the best of your knowledge describe the accident _____

_____

25. Describe how you felt, both physically and emotionally?

During impact: _____

Immediately after: _____

Later that day: _____

The next day: _____

26. At the time of the accident did you experience (please check all that apply):

☐ Ringing or buzzing in ears	☐ Loss of consciousness	☐ Confusion
☐ Disorientation	☐ Light headedness	☐ Flash of light/ explosion in head
☐ Blurred vision	☐ Dizziness	☐ Nausea

27. Since the accident have you experienced?

☐ Headache	☐ Neck Pain	☐ Stiff Neck	☐ Sleeping Problems	☐ Back Pain
☐ Nervousness	☐ Tension	☐ Irritability	☐ Chest pain	☐ Dizziness
☐ Pins & needles in arms		☐ Pins & needles in legs	☐ Numbness in fingers	☐ Numbness in toes
☐ Shortness of breath	☐ Fatigue	☐ Head seems too heavy	☐ Depression	☐ Ears Ringing
☐ Light bothers eyes	☐ Loss of memory	☐ Buzzing in ears	☐ Loss of balance	☐ Fainting
☐ Diarrhea	☐ Fever	☐ Constipation	☐ Loss of smell	☐ Loss of taste

☐ Other_____

28. List your current symptoms _____

_____

29. Which of the above symptoms were you suffering from prior to your accident? _____

_____

30. Overall, at this time is your condition ◯ improving ◯ becoming worse ◯ remaining the same

31. Have you previously been involved in any similar types of injuries? ◯ Yes ◯ No

Describe _____

WORK HISTORY

33. At the time of injury did you have a job? ◯ Yes ◯ No

34. What was the nature of your job? _____

35. Have you attempted to return to work ◯ Yes ◯ No If yes, what was the result _____

_____

36. Did you lose your job due to your injuries? ◯ Yes ◯ No - or - change jobs ◯ Yes ◯ No

If yes, explain the difference between your old job and your new job _____

_____

37. Have you lost time from work as a result of this accident? ◯ Yes ◯ No If yes, please complete:

Last day worked: _____ Present Salary: _____

Are you being compensated for time lost from work? ◯ Yes ◯ No If yes, please state type of

compensation you are receiving: _____

PLEASE READ BEFORE SIGNING

I, _____ had an injury related to an automobile accident on (date)_____. Until such time as my insurance is verified, I understand that I am fully responsible for any and all charges incurred by me at Life Care Center For Health & Wellness. I also understand that I am fully responsible for any services not covered by my insurance.

I agree to participate in medical and therapy treatments by this provider and accept that no guarantee of results or outcome is expressed.

Signature _____

Patients Name _____ Date _____