ACCIDENTAL INJURY REPORT

PENINSULA CHIROPRACTIC CENTER, INC.

Name: Date:

Date of Accident: _____ Hour ____ AM ____ PM Location _____

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

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
☐ Neck Stiff	☐ Dizziness	☐ Fatigue	☐ Loss of Balance	☐ Stomach Upset
☐ 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	☐ Other

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 Claim YES ☐ NO ☐

Do You Have An Attorney That Has Advise You In This Case? YES ☐ NO ☐

Attorney's Name _____ Address _____ Telephone _____