FRANCIS CHIROPRACTIC CLINIC, S.C.

Accidental Injury Worksheet

Name:_____Home Phone:_____Cell Phone:_____
Address:_____City:_____State:_____Zip:_____
Age:_____Birth Date:_____Occupation:_____
Employer:_____Office Phone:_____
Date of Accident:_____Time:_____
Location of Accident:_____City/State/County:_____
How did accident occur: ☐ Motor Vehicle Accident ☐ Other
If not auto collision, please describe the circumstances:_____
_____
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
List the extent of the injuries as you know them:_____
_____
_____
Have you seen a Doctor for this injury before coming to this office? ☐ Yes / ☐ No
If Yes: When:_____ Where:_____
Did you receive treatment? ☐ Yes / ☐ No If so, describe:_____
_____
Did you receive post-accident hospitalization? ☐ Yes / ☐ No

Check Symptoms You Have Noticed Since Accident:

☐ Headache	☐ Tension	☐ Numbness in fingers	☐ Light bothers eyes
☐ Neck Pain	☐ Chest Pain	☐ Numbness in toes	☐ Loss of memory
☐ Neck Stiffness	☐ Hip Pain	☐ Shortness of breath	☐ Ears ring
☐ Sleeping Problems	☐ Stomach Upset	☐ Fatigue	☐ Dizziness
☐ Back Pain	☐ Head seems too heavy	☐ Depression	☐ Loss of balance
☐ Shoulder Pain	☐ Pins & needles in arms	☐ Diarrhea	☐ Fever
☐ Nervousness	☐ Pins & needles in legs	☐ Constipation	☐ Other, specify_____

Have you lost any days of work? ☐ Yes / ☐ No If yes, dates_____
Has the insurance company been contacted: ☐ Yes / ☐ No

Additional information about the accident you think we should know:_____
_____
_____
_____

Patient's Signature :_____Date:_____

September 2013