FINNELL CHIROPRACTIC GROUP

Name_____ Date_____

Date of Accident_____ Time_____ Location_____

What type of accident occurred? Auto Collision On-the-job Injury Other

Please describe how the accident occurred: _____

_____

_____

Did you report the injury to your foreman or employer? Yes No

If auto accident, were you the... Driver Passenger Pedestrian

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

Or did the other car strike yours? Yes No Undetermined

Were you struck from... Behind Front Right Side Left Side Car was parked

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

Name and location of hospital: _____

Have you lost any days from work? Yes No Dates _____

Circle symptoms you have noticed since the accident:

Headaches	Light bothers eyes	Loss of memory
Neck Pain	Neck stiff	Ears ringing
Sleep problems	Face flushed	Back pain
Buzzing in ears	Nervousness	Loss of balance
Tension	Fainting	Irritability
Loss of smell	Chest Pains	Diarrhea
Dizziness	Feet cold	Head seems too heavy
Hands cold	Tingling in arms	Tingling in legs
Stomach upset	Constipation	Numbness in fingers
Numbess in toes	Cold sweats	Fever
Shortness of breath	Loss of Taste	Fatigue
Depression	Confusion	

Symptoms other than above: _____

Insurance companies involved: My company: _____

Opposing party: _____

Have you been contacted by an insurance adjuster or company representative regarding this clam?

Yes No

Your Insurance claim number: _____

Name of Your Insurance Adjuster: _____ Adjuster's phone number:_____

Do you have Medical pay coverage? Yes No Amount: _____

Do you have an attorney in this case? Yes No

Attorney's Name: _____ Attorney's phone number:_____

Attorney's address:_____

SIGNATURE _____ DATE_____

GUARDIAN'S SIGNATURE _____ DATE _____