SUGAR HILL FAMILY CHIROPRACTIC

Date:_____/_____/_____

Name:_____________________________________
Address:___________________________________
City/State/Zip:______________________________
Date of Birth _____/_____/_____ M F
Social Security _____ - _____ - _____
Home Phone:______________________________
Work Phone:______________________________

Accident History General DOA:____/____/____
Time of Day:______
You were: ___Driver ___Front Seat Passenger
___Rear Seat Passenger ___Other
___Motorcycle Operator
___Motorcycle Passenger

Your Vehicle (Year,Make,Model)_____________________
Insurance Company_______________________
Policy #:__________________________________
Claim #:__________________________________
Phone #:__________________________________
*Med-Pay: Yes / No

Were you at fault? Yes / No

If no, name of at fault driver:________________
At Fault Vehicle (Year,Make,Model)__________________
Insurance Company_______________________
Policy #:__________________________________
Claim #:__________________________________
Phone #:__________________________________

Estimated speed at moment of accident:_____
___Stopped ___Slowing ___Accelerating
Road Conditions:
___Dry ___Damp ___Wet ___Snow ___Ice
Seatbelt:
___Wearing ___Not Wearing ___Don't Know
Head Restraints: (Head Rest)
___None ___Integral Type ___Don't Know
___Adjustable Type: ___Up ___Down
Head Position:
___Forward ___Left ___Right ___Up ___Down
Hands:
___One on Wheel ___Two on Wheel ___ N/A
Brakes Applied: Yes / No

DURING THE CRASH

Aware of impending crash? Yes / No
Body Thrown? Yes / No
Did your seat break? Yes / No
Did the air bag deploy? Yes / No
If Yes, were you struck? Yes / No
Did you strike your body on any part of the vehicle? Yes / No
If Yes, describe:____________________
____
____
Wearing Glasses or a hat? Yes / No
If Yes, still on after crash? Yes / No
Did you lose consciousness? Yes / No
If Yes, for how long?_______________

Estimated damage to your vehicle:
None Minimal Moderate Major

Estimated damage to other vehicle(s):
None Minimal Moderate Major

Were the police on the scene? Yes / No
If Yes, was a report made? Yes / No
REPORT # __________________________

SYMPTOMS: ___ Headache ___Dizziness
___ Nausea ___Confusion/Disorientation
___Neck Pain ___ Parastesia (numbness)
___Other :___________________________
If Yes, explain:____________________
____
Pain description: ___Dull ___Achy
___Sharp ___Nagging ___Constant
___Comes and Goes
___Spine Pain: Where?________________
____
___Extremity Pain: Where?____________
____

When did your symptoms first appear?
___Home ___Work ___Hospital
___Emergency Room ___At Accident Site

EMERGENCY DEPARTMENT

Did you go to an Emergency Department?
Yes / No
If yes: ___Exam ___X-rays
Body parts x-rayed? _______________
____
____

Results of Exam:___________________________

Labwork: Yes / No

Medication: Yes / No _____________________

Other:____________________________________

Home instructions: None / _______________
____

<u>Major Medical Insurance</u>
Company:_______________________________
Policy #:__________________________________
Are you the primary? Yes / No
If No, who is:_____________________________
Primary's DOB: _____/_____/_____
*Please provide front desk with a copy of your insurance card.

Additional Notes:________________________
____
____
____
____
____
____
____

OTHER DOCTORS SEEN

Dr.'s Name:____________________________

Specialty:______________________________

Date Last Seen:_____/_____/_____

Referred by:___________________________

Treatment Type:________________________

Treatment Frequency:_________________

Still currently being treated? Yes / No

Any Disabilities? Yes / No
If yes, describe:_____________________
____

OTHER DOCTORS SEEN

Dr.'s name:___________________________

Specialty:____________________________

Date Last Seen:_____/_____/_____

Referred by:__________________________

Treatment Type:_____________________

Treatment Frequency:________________

Still currently being treated? Yes / No

Any Disabilities? Yes / No
If yes, describe:____________________
____

*Please note: If there is Med Pay available we will bill your automobile insurance Med Pay. If there is no Med Pay, we will contact the at-fault insurance company to verify that payment will be sent directly to us. In the event that the at-fault insurance company will not pay us directly, you will be responsible for payment per visit. We will provide you with a bill to turn in to the insurance company for reimbursement. The ONLY exception to this is if you have retained an attorney.

Please sign below:

____ __________________________
Patient Date