Complete Chiropractic

5930 Hamilton Blvd.
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(610) 841-2204

Personal Injury History

Name _____ Date of Birth _____ Phone _____
Address_____ City _____ State _____ Zip _____
Social Security # _____ Your Ins. Co. _____
Policy # _____ Agent's Name _____ Agent's Phone # _____
Driver/Other Vehicle _____ Ins. Co. _____ Policy # _____
Have you retained an attorney? ( ) Yes ( ) No Name _____
Were there any witnesses? ( ) Yes ( ) No Name(s)_____

Nature of Accident:

1. Date of Accident: _____ Time of Day _____
2. Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat
3. Number of people in your vehicle? _____ Other Vehicle? _____
4. What direction were you headed? ( ) North ( ) East ( ) South ( ) West
   on (name of street) _____
5. What direction was the other vehicle headed? ( ) North ( ) East ( ) South
   ( ) West on (name of street) _____
6. Were you struck from: ( ) Behind ( ) Front ( ) Left side ( ) Right side
7. Were you knocked unconscious? ( ) Yes ( ) No. If yes, for how long? _____
8. Were you wearing a seatbelt ( ) Yes ( ) No
9. Were police notified? ( ) Yes ( ) No
10. In your own words, please describe accident: _____
    _____
    _____
11. Did you have any physical complaints BEFORE THE ACCIDENT?( )Yes ( ) No
    If yes, please describe in detail: _____
    _____
    _____
12. Please describe how you felt:
    a. DURING the accident: _____
    b. IMMEDIATELY AFTER the accident: _____
    c. LATER THAT DAY: _____
    d. THE NEXT DAY: _____
13. What are your PRESENT complaints and symptoms? _____
    _____
    _____
14. Do you have any congenital (from birth) factors which relate to this problem?
    ( ) Yes ( ) No. If yes, please describe: _____
    _____
15. Do you have any previous illnesses which relate to this case? ( ) Yes ( ) No
    If yes, please describe: _____
    _____
16. Have you ever been involved in an accident before? ( ) Yes ( ) No. If yes,
    please describe, including date(s) and type(s) of accidents, as well as injuries
    received. _____
    _____
    _____

17. Where were you taken after the accident? _____
18. Have you ever been treated by another doctor since the accident? ( ) Yes ( ) No.
If yes, please list doctor's name and address: _____
What type of treatment did you receive? _____
_____
19. Since this injury occurred, are your symptoms:
( ) Improving ( ) Getting Worse ( ) Same
20. 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

Symptoms Other Than Above _____
21. Have you lost time from work as a result of this accident? ( ) Yes ( ) No.
If yes, please complete this question.
a. Last Day Worked: _____
b. Type of Employment: _____
c. Are you being compensated for time lost from work? ( ) Yes ( ) No.
If yes, please state type of compensation you are receiving? _____
22. Do you notice any activity restrictions as a result of this injury?( ) Yes ( ) No.
If yes, please describe, in detail: _____
_____
_____
_____
23. Other pertinent information: _____
_____
_____
_____
_____
_____
_____
_____
_____

I have read and completed all answers to the above questions to the best of my knowledge. I am aware that answering yes to any of the above questions may require me to undergo further testing prior to starting any appropriate care. I hereby give my full consent to undergo a care program designed for me if determined to be clinically medically necessary by my doctor. I will notify them of any changes in my health status during the duration of the program. It is also my duty to daily inform the doctor or assistant of any possible complication prior to the initiation of my daily treatment.

Your signature _____ Date _____

Physician signature _____ Date _____