IF YOURS IS AN ACCIDENTAL INJURY PLEASE COMPLETE THE FOLLOWING QUESTIONS

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

How did Accident occur ? ❑ Auto Collision ❑ On-the-job Injury ❑ Other _____

If not an auto collision, 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

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
- ❑ Neck Pain
- ❑ Neck Stiff
- ❑ Sleeping Problems
- ❑ Back Pain
- ❑ Nervousness
- ❑ Tension
- ❑ Irritability
- ❑ Chest Pain
- ❑ Dizziness
- ❑ Head Seems Too Heavy
- ❑ Pins and Needles in Arms
- ❑ Pins and Needles in Legs
- ❑ Numbness in Fingers
- ❑ Numbness in Toes
- ❑ Shortness of Breath
- ❑ Fatigue
- ❑ Depression
- ❑ Light Bothers Eyes
- ❑ Loss of Memory
- ❑ Ears Ring
- ❑ Face Flushed
- ❑ Buzzing in Ears
- ❑ Loss of Balance
- ❑ Fainting
- ❑ Loss of Smell
- ❑ Loss of Taste
- ❑ Diarrhea
- ❑ Feet Cold
- ❑ Hands Cold
- ❑ Stomach Upset
- ❑ Constipation
- ❑ Cold Sweats
- ❑ Fever
- ❑ _____
- ❑ _____

Symptoms other than above _____

Have you lost any days of work? ❑ YES ❑ NO DATES: _____

Insurance Companies involved:

My Company _____ Claim Number _____ Phone Number _____

Company of person responsible for injuries? _____ Claim Number _____ Phone Number _____

Have you been contacted by an insurance adjuster or company representative regarding this claim? ❑ YES ❑ NO

Do you have an attorney that has advised you in this care? ❑ YES ❑ NO

Name _____

Address _____ Telephone _____

BRADLEY CHIROPRACTIC CENTER

4900 NORTH LITCHFIELD ROAD, SUITE C-2 • LITCHFIELD PARK, AZ 85340 • (623) 547-0922

Insurance Information
Auto Accident

Date: _____ Date of Accident: _____

Patient name: _____

Patient Insurance Coverage

Insurance Company: _____

Name on Policy: _____

Policy Number: _____ Claim Number: _____

Contact Name: _____ Phone: _____ Ext: _____

Address: _____

_____

Do you have Medical Pay Coverage? _____

Responsible Party Insurance Coverage

Insurance Company: _____

Name on Policy: _____

Policy Number: _____ Claim Number: _____

Contact Name: _____ Phone: _____ Ext: _____

Address: _____

_____

Attorney Information

Attorney Name: _____

Contact Name: _____ Phone: _____ Ext: _____

Address: _____

_____