FULL CIRCLE CHIROPRACTIC & WELLNESS CENTER L.L.C.
ACCIDENT/INJURY FORM

NAME_______________________________________
DATE_____________________

Date of Accident__________ Time: ___am ___pm Location of Accident________________

AUTO INJURY
As a result of the Accident, were traffic citations issued to you? __ Yes __ No

ON-THE-JOB INJURY
How did the injury occur?

____

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

Employer:_________________________

Address:___________________________________

OTHER
Describe the circumstances of the accident (Be Specific)____
____

CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT

( ) Headache
( ) Neck Pain
( ) Neck Stiff
( ) Dizziness
( ) Back Pain
( ) Nervousness
( ) Tension
( ) Irritability
( ) Chest Pain

( ) Sleeping Problems
( ) Head Too Heavy
( ) Pins & Needles in Arms
( ) Pins & Needles in Legs
( ) Numbness in Fingers
( ) Numbness in Toes
( ) Shortness of Breath
( ) Fatigue
( ) Depression

( ) Lights Bother Eyes
( ) Loss of Memory
( ) Ears Ringing
( ) 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
( ) Other

Did you require post-accident hospitalization? __ Yes __ No
Have you lost any days of work? __ Yes __ No If Yes, _________ through ________

INSURANCE INFORMATION

Your Insurance Company___________________________

Address_______________________

Other Party Name________________________________

Address_____________________

Other Party's Ins. Company______________________________

Address________________________

Have you been contacted by an insurance adjustor regarding this claim

__ Yes __ No

If yes, **name of adjustor** ____________________Company ______________________

Do you have an attorney that has advised you in this case: __ Yes __ No

If yes, **attorney's name** ____________________________

Address____

THE FOLLOWING QUESTIONS PERTAIN TO YOU AND THE VEHICLE YOU WERE IN:

Vehicle type:
__Car __Pickup
__Van __TrucK
__Station Wagon __Bus
__Other__________

Vehicle size:
__Subcompact __Full-size
__Compact __Mini
__Mid-size __Light

Your position in the vehicle:
__Driver __Passenger __Front Passenger __Rear Passenger __Third Seat (rear)

Speed of your vehicle:
__Stopped __Moving moderately
__Parked __Moving Fast
__Slowing __Moving at approx. ____MPH
__Moving slowly

Why Vehicle was slowed or stopped:
__Traffic Signal __Parking
__Pedestrian __Traffic
__Stop Sign __Busy Intersection

Collision Type:
__Driver Side Impact __Head On Collision
__Passenger Side Impact __Rear Impact
__Front Impact __Pedestrian Incident

THE FOLLOWING QUESTIONS CONCERN THE OTHER VEHICLE INVOLVED IN THE ACCIDENT:

Vehicle type:
__Car __Pickup
__Van __Truck
__Station Wagon
__Other________________

Vehicle size:
__Subcompact __Full-size
__Compact __Mini
__Bus __Mid-size
__Heavy __Other________

CONDITIONS AT THE TIME OF THE ACCIDENT:

Time of day:
__Full daylight
__Dawn
__Dusk
__Night

THE FOLLOWING QUESTIONS CONCERN THE MOMENT OF IMPACT OF THE COLLISION:

Were you
__Totally unaware that the accident was impending
__Aware that the accident was impending
__Aware that the accident was impending and braced for it

Restraints: (check all that apply)
__Seat belt
__Shoulder harness
__No restraints

If you were the driver of the vehicle, was your foot on the brake pedal? __Yes __No
__Knocked off by impact

Was the air bag deployed?
__Car not equipped with air bag
__Air bag deployed
__Air bag not deployed

What position was YOUR headrest In
__High position
__Middle position
__ Low position

Position of YOUR head at time of impact
__Facing straight ahead
__Tilted forward
__Rotated to the left
right
__Rotated to the right
left

Was your head thrown
__Backward and then forward
__Forward then backward
__To the left __To the left then the
__To the right __To the right, then the

Position of YOUR body at time of impact
__Straight
__Tilted forward
__Rotated to the left
then the right
__Rotated to the right
then the left

Your body thrown
__Backward and then forward
__Forward then backward
__To the left __To the left
__To the right __To the right,
__Across the vehicle
__Outside the vehicle __Under vehicle

Damage to vehicle YOU were in:
__Incurred minimal damage
__Incurred moderate damage
__Incurred severe damage
passenger of
__Was totaled
__Not known

Citations:
__None issued
__Yourself
__Driver of vehicle patient was a
__Driver of other vehicle
__Not sure

AS A RESULT OF THE FORCE OF THE COLLISION, WHICH OBJECTS IN THE VEHICLE DID YOUR BODY STRIKE?

Head **Left Arm**

__Steering wheel __Right door __Steering wheel __Right
door
__Dashboard __Left window __Dashboard __Left
window
__Windshield __Right window __Windshield __Right
window
__Armrest __Console __Armrest __Console
__Headrest __Gear shift __Headrest __Gear
shift
__Rear view mirror __Front seat __Rear view mirror __Front
seat
__Left door __Backseat __Left door __Backseat

Right Arm **Torso**

__Steering wheel __Right door __Steering wheel __Right
door
__Dashboard __Left window __Dashboard __Left
window

__Windshield __Right window __Windshield __Right
window
__Armrest __Console __Armrest __Console
__Headrest __Gear shift __Headrest __Gear
shift
__Rear view mirror __Front seat __Rear view mirror __Front
seat
__Left door __Backseat __Left door __Backseat

Left Leg **Right Leg**

__Steering wheel __Right door __Steering wheel __Right
door
__Dashboard __Left window __Dashboard
__Windshield __Right window __Windshield __Right
window
__Armrest __Console __Armrest __Console
__Headrest __Gear shift __Headrest __Gear
shift
__Rear view mirror __Front seat __Rear view mirror __Front
seat
__Left door __Backseat __Left door __Backseat

THE FOLLOWING QUESTIONS CONCERN THE TIME PERIOD IMMEDIATELY FOLLOWING THE ACCIDENT:

Did you lose consciousness?

__Yes
__No

Immediately following the accident, did you feel?

__Dizzy	__Weak
__Dazed	__Nervous
__Disoriented	__Nauseated

Were you able to walk unaided?

__Yes
__No

Where did you go...?

__Drove home	__Drove to work
__Was driven home	__Was driven to work
__Drove to hospital	__Drove to school
__Was driven to hospital	__Was driven to school
__Taken to hospital via ambulance	

Next day discomfort?

__ increased __decreased __same

Did your major complaints exist before the accident?

__Yes __ No

In what areas did you IMMEDIATELY feel pain?

__Head	__Shoulder	__Left __Right	__Hip	__Left __Right
__Neck	__Arm	__Left __Right	__Thigh	__Left __Right
__Upper back	__Elbow	__Left __Right	__Knee	__Left __Right
__Mid back	__Wrist	__Left __Right	__Calf	__Left __Right
__Ribs	__Hand	__Left __Right	__Ankle	__Left __Right
__ Chest	__Fingers	__Left __Right	__Foot	__Left __Right
__Abdomen	__Buttock	__Left __Right	__Toes	__Left __Right
__Low back	__Pelvis			

In what areas did you experience lacerations (cuts)?

__Head	__Shoulder	__Left __Right	__Hip	__Left __Right
__Neck	__Arm	__Left __Right	__Thigh	__Left __Right
__Upper back	__Elbow	__Left __Right	__Knee	__Left __Right
__Mid back	__Wrist	__Left __Right	__Calf	__Left __Right
__Ribs	__Hand	__Left __Right	__Ankle	__Left __Right
__Chest	__Fingers	__Left __Right	__Foot	__Left __Right
__Abdomen	__Buttock	__Left __Right	__Toes	__Left __Right
__Low back	__Pelvis			

At the hospital, what areas were x-rayed?

__Head	__Shoulder	__Left __Right	Hip	__Left __Right
__Neck	__Arm	__Left __Right	Thigh	__Left __Right
__Upper back	__Elbow	__Left __Right	Knee	__Left __Right
__Mid back	__Wrist	__Left __Right	Calf	__Left __Right
__Ribs	__Hand	__Left __Right	Ankle	__Left __Right
__Chest	__Fingers	__Left __Right	Foot	__Left __Right
__Abdomen	__Buttock	__Left __Right	Toes	__Left __Right
__Low back	__Pelvis			

Where did you experience pain on the day FOLLOWING the accident?

__Head	__Shoulder	__Left	__Right	__Hip	__Left	__Right
__Neck	__Arm	__Left	__Right	__Thigh	__Left	__Right
__Upper back	__Elbow	__Left	__Right	__Knee	__Left	__Right
__Mid back	__Wrist	__Left	__Right	__Calf	__Left	__Right
__Ribs	__Hand	__Left	__Right	__Ankle	__Left	__Right
__Chest	__Fingers	__Left	__Right	__Foot	__Left	__Right
__Abdomen	__Buttock	__Left	__Right	__Toes	__Left	__Right
__ Low back	__Pelvis					

Patient's Signature:____
Date:________________

Guardian's Signature Authorizing Care:__________________________
Date:________________