DeCrescenzo Chiropractic

Personal Injury Form

GENERAL INFORMATION

Date: __/____/20____ Referred by: _____

Full Name: _____ SS #: _____
First Name Middle Name Last Name

Address: _____
№ Street Name Apt № City State Zip Code

Age: ____ Date of Birth: _____ Sex: □ Male □ Female Marital Status: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email Address: _____@_____.com

Employer: _____ Occupation: _____

Primary Care Physician Name:_____ Phone:_____

Address:_____

Emergency Contact: _____ Relation: _____

Contact Phone: _____

INJURY INFORMATION:

Date of incident: _____

Where did injury occur: _____

City & State the injury occurred: _____

Please describe the incident in your own words: _____

_____

_____

Did any part of your body strike anything? □Yes □No If yes, explain: _____

_____

Who is responsible for your injuries:_____

Did injury occur at a business establishment: □Yes □No

If Yes, Name and address of business: _____

Do you know the insurance information of the responsible party? □Yes □No

If yes, please list Name, Address and Phone Number of Insurance Company: _____

_____

Did police arrive on scene? □Yes □No

Was a police Report filed? □Yes □No

Did you have immediate pain following the incident? □Yes □No

Are your symptoms affecting your daily activities? □Yes □No

PATIENT CONDITION & TREATMENT:

Did you lose consciousness? □Yes □No If yes, for how long? _____

What were your symptoms following the incident? _____

Did you go to the hospital? □ □Yes □No If yes, name of hospital: _____

When did you go? □ Immediately after accident □ Later that day □ Next day □ other: _____

Transported by ambulance? □ □Yes □No Do you have any of the following: □ **Cuts** □ **Scrapes** □ **Bruises**

Were x-rays performed? □ □Yes □No If yes, which body part? _____

Were any other tests performed? □□Yes □No If yes, what tests? _____

Was medication prescribed? □ □Yes □No If yes, what medications? _____

Are you pregnant? □ □Yes □No If yes, due date: _____

Do you smoke? □ □Yes □No If yes, how much: _____ Drink alcohol? □Yes □No If yes, how much: _____

SYMPTOMS/INJURIES:

Have you been able to work since this injury? □ Yes □ No How many work days have you missed? _____

Please check your symptoms since your injury:

□ □Headaches □Neck pain □ □Neck stiffness □ □Jaw problems

□left/□right Arm pain □ left/□right Shoulder pain □left/□right □Hand/□finger □pain/□numbness

□Mid-back pain □Back stiffness □ Chest pain □Low back pain □□left/□right □Hip pain

□left/□right Leg pain □left/□right □Knee/□Ankle pain □left/□right □Foot/□Toe □pain/□numbness

□ □Dizziness □ □Nausea □ □Fatigue □ □Sleep difficulty □Abdominal pain

□ Difficulty turning head to the □right/□left □ Vision blurred □ Hearing loss / Balance

Does coughing/sneezing increase your pain? □ Yes □ No

Are your symptoms getting worse? □ Yes □ No Is it constant or does it come and go? _____

Rate the severity of your pain on a scale from 1 (lease pain) to 10 (severe pain) _____

INSURANCE/ATTORNEY INFORMATION:

Has a claim been filed with an insurance company?
□Yes □No
What is your claim #: _____
Do you have an Attorney? □ □Yes □No
If yes, what is his/her name? _____
Do you have health insurance? □ □Yes □No
If yes, please give your insurance card to the front desk.

POLICE:

Did the police come to the accident site? □Yes □No
Were there any witnesses? □Yes □No □
Was a police report filed? □Yes □No
If yes, please give the front desk a copy

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patent, Parent, Guardian or Personal Representative Relationship to Patient