

The Back Clinic

Chiropractic Acute Care Services

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PERSONAL INJURY INFORMATION

Name: _____ Age _____ DOB _____
Address _____ [] M [] F
Telephone _____ Social Security Number _____

ACCIDENT

Date _____ Time _____ Place _____
How did the accident happen? _____

Have you reported the accident? [] yes [] no
If yes, to Whom? _____
Has a formal report of accident been filed? [] yes [] no

INJURY

What is your main injury? _____
Have you seen another doctor? [] yes [] no
If yes, when? _____ What was the diagnosis? _____
Was any treatment / medication prescribed? [] yes [] no What? _____

Have you been hospitalized? [] yes [] no Date admitted _____
If yes, what hospital? _____ Date discharged _____
Are you going to file a lawsuit? [] yes [] no [] under consideration

DISABILITY

Have you continued work? [] yes [] no Have you been disabled? [] yes [] no
If disabled, date disability began _____ Have you returned to work [] yes [] no
Fully describe your impairment _____

SKETCH

Please sketch a brief diagram how the accident happened. (Stick figures are good)

Patient's Signature _____ Date _____