Vehicle Accident Information

(770) 368-0333

Rick Neal, DC

Peachtree Corners Chiropractic Clinic

Please answer all questions completely and then consult your chiropractor!

Number: _____ Date: _____

Patient: _____ Home Phone: _____

Gender: Male Female Marital Status: Single Married Widowed Separated Divorced

Date of Birth: _____ Occupation: _____

Address: _____ City: _____

State: _____ Zip: _____

Referred By: _____ Social Security #: _____

Company: _____ Business Phone: _____

Please explain in detail how your accident happened: _____

_____

_____

_____

_____

Other vehicle (if any) insurance:

Driver: _____ Insurance Company: _____

Phone: _____ Address: _____

Policy No: _____ Claim No: _____

Insurance for vehicle you were in:

Driver: _____ Insurance Company: _____

Phone: _____ Address: _____

Policy No: _____ Claim No: _____

Name of person who has made contact with you: _____

Have you retained an attorney? Yes No Not Yet

If so, please provide their information: Attorney Name: _____

Phone: _____ Address: _____

About the accident:

Time: _____ AM or PM? AM PM

Date: _____ Police Notified? Yes No

Heading? N S E W On (name of road): _____

Number of people traveling in vehicle you were in: _____

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(Other Vehicle)

Heading? N S E W On (name of road): _____

Number of people traveling in other vehicle: _____

Your injury:

Did head strike windshield or object? Yes No

Were you knocked unconscious? Yes No

If so, for how long? _____

You were struck from: Behind Front Left Side Right Side

Where were you sitting? Front Seat Back Seat

Were you the driver or a passenger? Driver Passenger

Were you wearing your seat belt? Yes No

Other protective devices (e.g., air bags)? Yes No

Did you feel pain immediately? Yes Later that day Next day

If none of above, when did the pain begin? _____

If immediately, where did you feel pain? _____

Treatment given:

Where were you taken after the accident? _____

Was any doctor consulted after the accident? Yes No

If so, give doctor's name: _____

What type of doctor is he/she? DC MD OD DDS

What was the doctor's diagnosis? _____

What treatment was given? _____

How often did you see the doctor? _____

How long did you see the doctor? _____

Complaint history:

Have you ever had any complaints in the involved area before? Yes No

If so, what were the complaints? _____

_____

_____

_____

_____

Before the injury, could you work equal to others your age? Yes No

Are your work activities restricted as a result of this accident? Yes No

Since the injury, are your symptoms: Improving? Getting worse? The same?