NEWBOLD CHIROPRACTIC

Phone 650-726-3300

AUTO RELATED ACCIDENT

Name: _____ Today's Date:_____
Please fill out this section if your accident was **AUTO RELATED:**
Date & Time of Auto Accident: _____ □a.m. □p.m.
If a traffic violation was issued, to whom was it issued? _____
Number of people in accident vehicle? _____ Did the police come to the accident site? □Yes □No
Was a police report filed? □Yes □No Were there any witnesses? □Yes □No
Was this vehicle equipped with airbags? □Yes □No If yes, did they inflate? □Yes □No
Were you wearing a seatbelt? □Yes □No
In relation to the base of your skull, where was the headrest? □Above □Below □At base of skull
What did your vehicle impact? □Another vehicle □Other If other, explain _____
Make & Model of the vehicle you were occupying? _____
Name of the location/street you on which you were traveling? _____
In which direction were you headed? N S E W What was the approx. speed of your vehicle? _____
Were you □ aware or □ surprised by the impact?
If accident vehicle made impact with another vehicle: Make and Model of that other vehicle? _____
Direction other vehicle was heading? N S E W Speed of other vehicle _____

In your own words, please describe the accident: _____
_____
_____
Were you the: □ Driver □ Front Passenger □ Rear Passenger
Did any part of your body strike anything in the vehicle you were occupying? □Yes □No
If yes, please explain _____
Did the impact to your vehicle come from the: □Front □Rear □Right Side □Left Side □Other
During the impact, were you facing: □Right □Left □Forward Was your head turned: □Right □Left □Forward
Have you retained an attorney? □Yes □No If yes, whom:_____ His/Her phone #_____

Your Auto Insurance

Insurance Co.: _____
Address: _____
Agent's Name: _____ Insured's Name: _____
Agent's Phone #: _____ Insured's D.O. B. _____
Claim #: _____ Insured's SS #: _____

- **We invite you to discuss with us any questions you have regarding our services.**
- **Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no other financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account. Please remember you are ultimately responsible for your account.**
- **I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.**
  Signature_____Date_____

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AFTER INJURY

Did the accident render you unconscious? ☐Yes ☐No If yes, for how long? _____
Please describe how you felt immediately after the accident: _____
Have you gone to a hospital or seen any other Doctor? ☐Yes ☐No
When did you go? ☐Just after accident ☐Next Day ☐ 2 plus days
How did you get there? ☐Ambulance ☐Private transportation
Name of hospital and attending physician? _____
Was your doctor a: ☐D.C. ☐M.D. ☐D.O. ☐D.D.S.
Describe any special treatment you received: _____
_____
Were X-rays taken?..... ☐Yes ☐No
Was medication prescribed?..... ☐Yes ☐No
Have you been able to work since this injury?..... ☐Yes ☐No
Indicate the symptoms that are a result of this accident:

☐Dizziness	☐Difficulty sleeping	☐Jaw problems	☐Nausea
☐Memory loss	☐Irritability	☐Arms/shoulder pain	☐Back pain
☐Headache	☐Fatigue	☐Numb hands/fingers	☐Lower back pain
☐Blurred vision	☐Tension	☐Chest pain	☐Back stiffness
☐Buzzing in ear	☐Neck pain	☐Shortness of breath	☐Leg pain
☐Ears ringing	☐Neck stiff	☐Stomach upset	☐Numb feet/toes

Is your condition getting worse? ☐Yes ☐No ☐Constant ☐Comes and Goes

Indicate your degree of comfort while performing the following activities:

	Comfortable	Uncomfortable	Painful even if only sometimes
Lying on back ……..	☐ ……..	☐ ……	☐
Lying on side ……..	☐ ……..	☐ ……	☐
Lying on stomach …….	☐ ……..	☐ ……	☐
Sitting ……..……..	☐ ……..	☐ ……	☐
Standing ……..……..	☐ ……..	☐ ……	☐
Stretching ……..……	☐ ……..	☐ ……	☐
Lovemaking ……..….	☐ ……..	☐ ……	☐
Walking ……..……..	☐ ……..	☐ ……	☐
Running ……..……..	☐ ……..	☐ ……	☐
Sports ……..……..	☐ ……..	☐ ……	☐
Lifting ……..	☐ ……..	☐ ……	☐
Bending ……..……..	☐ ……..	☐ ……	☐
Kneeling ……..……..	☐ ……..	☐ ……	☐
Pulling ……..……	☐ ……..	☐ ……	☐
Reaching .....……	☐ ……..	☐ ……	☐

To evaluate the effect that continuing to work will have on your recovery please complete the following:
How many hours are in your normal workday? _____
Please indicate your job duties and any activities which you are occasionally asked to perform:
☐Standing ☐Driving ☐Operating equipment ☐Sitting ☐Twisting
☐Walking ☐Crawling ☐Typing ☐Work with arms above head
☐Lifting ☐Bending ☐Stooping ☐Other _____
What positions can you work in with minimum physical effort and for how long? _____
Prior to the injury were you capable of working on an equal basis with others your age? ☐Yes ☐No ☐N/A
Do you work with others who can help you with any heavy lifting?..... ☐Yes ☐No ☐N/A
While in recovery, is there any light duty work you could request?..... ☐Yes ☐No ☐N/A