Buzek CHIROPRACTIC
41 Princess Street, Leamington, ON
519.322.4859 • www.buzekchiropractic.ca

ACCIDENT-RELATED COMPLAINT

Patient Information:

Name: _____ Date: _____
Date of Birth: _____ Age: _____ Sex: □ Male □ Female

Accident-Related Complaint

Is your complaint due to a: □ Motor Vehicle Accident □ Work-Related Injury
What is the date of your injury? _____

Motor Vehicle Accident (Please complete if related to a car accident)

In your own words, please describe the accident: _____

_____

_____

Were you the: □ Driver □ Passenger
Where were you seated in the vehicle? □ Front □ Back □ Driver's side □ Passenger's side
Your vehicle was hit from the: □ Front □ Rear □ Side
How many impacts were there? _____
Were you wearing your seatbelt? □ Yes □ No
Did your airbags deploy? □ Yes □ No
Did you black out? □ Yes □ No □ Not sure
Did you have your head turned? □ Yes □ No □ Not sure
Did police come to the scene? Yes □ No
Was a citation written? □ Yes □ No If yes, to whom? _____
Did ambulance come to the scene? □ Yes □ No
Were you transferred to hospital? □ Yes □ No
Have you seen any other provider? □ Yes □ No
If yes, please list:
Name: _____ Phone: _____
Name: _____ Phone: _____
Name: _____ Phone: _____
Please list any other treatment/care you have had for this injury: _____

_____

_____

Work-Related Accident (Please complete if related to a work injury)

In your own words, please describe the accident: _____

_____

_____

Have you reported this to your supervisor? □ Yes □ No
Have you injured yourself at work before? □ Yes □ No When: _____
Have you experienced this symptom before? □ Yes □ No When: _____
Do you have an open claim for this injury? □ Yes □ No If yes, please notify the front desk staff.
Have you seen any other provider for this injury? □ Yes □ No
Name: _____ Phone: _____
Please list any other treatment/care you have had for this injury: _____

_____