Shippy Chiropractic – Accident Report

Name ____SS# ________-________-__________
Address ______________________________City ____________State ______Zip _____________
Cell Phone(_____)_____-______Home Phone(____)_____-_______Work Phone(____)_____-______
Sex _______Birth Date _____/_____/_______Age _____Email ______________________________
Date of Accident ______________________Time _________ Place _________________________
Describe how accident / injury happened ____
____
____
Describe symptoms since accident / injury ____
____
Did you have any of these symptoms prior to the accident /injury? ❑ Yes ❑ No
If yes, please explain ____
Have you lost any time from work due to your injuries? ❑ Yes ❑ No
If yes, please explain ____
Have you been examined or treated for injuries? ❑ Yes ❑ No If yes, please fill out next 2 lines.
Doctor or Hospital ______________________Dates seen_________________________________
Treatments given____

Check all symptoms you have noticed at any time since the accident / injury.

❑ Headache	❑ Irritability	❑ Pins & Needles in arms	❑ Feet Cold	❑ Loss of Balance
❑ Neck Pain	❑ Chest Pain	❑ Pins & Needles in legs	❑ Hands Cold	❑ Fainting
❑ Neck Stiffness	❑ Loss of Taste	❑ Numbness in fingers	❑ Light bothers eyes	❑ Loss of Smell
❑ Sleeping Problems	❑ Diarrhea	❑ Numbness in toes	❑ Loss of Memory	❑ Stomach Upset
❑ Back Pain	❑ Fever	❑ Shortness of breath	❑ Ears Ring	❑ Constipation
❑ Nervousness	❑ Dizziness	❑ Fatigue	❑ Face Flushed	❑ Cold Sweats
❑ Tension	❑ Head seem heavy	❑ Depression	❑ Buzzing in ears	❑ Other __________

Please fill out only the following sections which apply to you and sign at the bottom.

WORKERS COMPENSATION

Name of Employer ____________________________________Emp. Phone# __________________
Emp.Address____
Attorney's Name _____________________________________Atty. Phone# ___________________

AUTOMOBILE ACCIDENT

Your Auto Insurance Co. _______________________________Ins. Phone# ____________________
Adjusters Name ______________________________________Policy# _______________________
Other Party's Auto Ins. Co. ____________________________Phone# ________________________
Adjusters Name ______________________________________Policy# _______________________
Your Health Ins. Co. __________________________________Policy# ________________________
Attorney's Name _____________________________________Atty. Phone# ___________________

LIABILITY CLAIM

Your Health Ins. Co. __________________________________Policy# ________________________
Attorney's Name _____________________________________Atty. Phone# ___________________

I understand the above information to be accurate and true to the best of my knowledge.

Patient Signature ______________________________________ *Date* ___________________