FRAY CHIROPRACTIC
DAVID E. FRAY, D.C.

INJURY REPORT

Patient name:_____ **Date:** _____

Date of Accident:_____ **Hour (am/pm)**_____ **Location:**_____

How did accident occur? _____ Auto Collision _____ On the Job _____Other

Please describe the circumstances: _____

_____

_____

If it was an <u>on the job injury</u>, did you report the injury to your foreman or employer?

_____ YES _____ NO

If so, did they recommend care at this office?
_____ YES _____ NO

<u>If an auto accident</u>, were you: _____Driver _____Passenger _____Pedestrian

<u>If auto collision</u>, were you struck from:
_____Behind _____Right Side _____Left Side _____Front _____Auto was parked

Did your car strike the other(s) involved? _____ YES _____ NO
Did the other car strike yours? _____ YES _____ NO
As a result of the accident were traffic citations issued to you? _____ YES _____NO
If you weren't driving, were citations issued to the driver of the car? _____YES _____NO

List the extent of your injuries as you know them: _____

_____

_____

Were you taken to the Emergency Room at the hospital? _____ YES _____ NO
Were you admitted to the hospital? _____ YES _____ NO
If yes, how long did you stay in the hospital? _____

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Patient's Name: _____ **Date:**_____

Check symptoms that you have noticed since the accident:

Headaches _____	Dizziness _____	Depression _____
Stomach Upset _____	Lights bother eyes _____	Buzzing in Ears _____
Neck Pain _____	Head seems too heavy _____	Loss of Memory _____
Fainting _____	Pins & Needles _____	Ears Ring _____
Face Flushed _____	Sleeping Problems _____	Loss of Balance _____
Nervousness _____	Pins & Needles in Legs _____	Constipation _____
Irritability _____	Numbness in Toes _____	Loss of Smell _____
Cold Sweats _____	Shortness of Breath _____	Loss of Taste _____
Diarrhea _____	Cold Feet _____	Fatigue _____
Back Pain _____	Tension _____	Cold Hands _____
Chest Pain _____	Numbness of Fingers _____	

Symptoms other than above: _____
_____

Have you missed any work due to this accident? If so, how much have you missed?
_____

Your Insurance Company name: _____
Address: _____
Phone #: _____ Claims Adjuster name: _____
Claim #: _____

Insurance Company name of other party involved: _____
Address: _____
Phone #: _____ Claims Adjuster name: _____
Claim #: _____

Do you have an attorney that has advised you in the case? _____ YES _____ NO

If yes, Attorney's name:_____
Attorney's address: _____
Phone #: _____

<u>Authorization for Treatment:</u>
Patient Name (please print) _____

Patient's Signature: _____ Date: _____