

VEHICLE ACCIDENT INFORMATION

GRIMSLEY CHIROPRACTIC SERVICES, P.C.

22780 Three Notch Road Lexington Park, MD 20653

Phone: (301)-737-0662 Fax: (301)-737-0675

PATIENT INFORMATION

Date: _____

Patient Name _____ Date of Accident _____

Time of Accident _____ [] a.m. [] p.m. Location _____

Were You The: [] Driver [] Rear Passenger [] Front Passenger [] Pedestrian

Describe The Accident In Your Own Words: _____

Were You Unconscious Immediately After The Accident? [] Yes [] No If Yes, For How Long? _____

Where Did You Feel Pain Immediately After The Accident? _____

IMPACT

Did Your Car Impact Another Vehicle? [] Yes [] No

Did Your Car Impact A Structure? [] Yes [] No

If Yes Explain _____

Did Any Part Of Your Body Strike Anything In The Vehicle? [] Yes [] No If Yes Explain _____

Impact Was From [] Front [] Rear [] Left [] Right
At The Time Of Impact Were You:

[] Looking Straight Ahead [] Looking Down

[] Looking To The Left [] Looking To The Right

[] Looking Up

Were You: [] Surprised By Impact [] Braced For Impact

Did Police Come To The Accident? [] Yes [] No

Were There Witnesses? [] Yes [] No

Was A Police Report Filed? [] Yes [] No

Was A Violation Issued? [] Yes [] No

If Yes, To Whom? _____

VEHICLE INFORMATION

Make & Model Of Vehicle You Were In _____

Make & Model Of Other Vehicle _____

Were You Wearing A Seatbelt? [] Yes [] No [] Lap or [] Shoulder

Did Air Bags Deploy? [] Yes [] No

Did Your Seat Have A Headrest? [] Yes [] No

ACCIDENT INFORMATION

Address, City & State Of Accident: _____

Nearest Intersection With Road/Street _____

Which Direction Were You Headed? _____

Which Direction Was The Other Vehicle Heading _____

Driver Of Vehicle In Which You Were Traveling _____

Driver Of Other Vehicle _____

TREATMENT

Did You Go To The Hospital? [] Yes [] No If Yes, When: [] Immediately After The Accident [] The Next Day [] 2 or More Days

How Did You Get To The Hospital? [] Ambulance [] Private Transportation

Name Of Hospital: _____ Doctor's Name _____

Treatment Received: _____ X-Ray's? [] Yes [] No

Diagnosis: _____

INSURANCE & ATTORNEY INFORMATION

Name Of The Auto Insurance For The Vehicle You Were Driving/Passenger In _____

Name Of The Policy Holder: _____

Policy #: _____ Claim #: _____

Adjuster's Name: _____ Phone _____

Insurance Company For The Other Vehicle Involved: _____

Name Of The Policy Holder: _____ Policy # _____

Claim #: _____ Adjuster's Name: _____ Phone: _____

Have You Retained An Attorney? [] Yes [] No If Yes,

Name _____

Address _____ Phone: _____

SYMPTOMS & INJURIES

Have You Been Able To Work Since This Injury? Yes No How Many Days Have You Missed? _____

Before The Accident Were You Able To Work On An Equal Basis With Others Your Age? Yes No

Check Any Of The Following Symptoms You Have Had Since The Accident:

- | | | |
|--|---|--|
| <input type="checkbox"/> Arm/Shoulder Pain | <input type="checkbox"/> Feet/toe Numbness | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Hand/finger Numbness | <input type="checkbox"/> Neck Stiffness |
| <input type="checkbox"/> Back Stiffness | <input type="checkbox"/> Headaches | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Irritability | <input type="checkbox"/> Sleep Difficulty |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Jaw Problems | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Ear Buzzing | <input type="checkbox"/> Leg Pain | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Ear Ringing | <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Vision Blurred |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Nausea | |

Is This Condition Getting Worse? Yes No Not Sure

Rate Your Pain On A Scale Of 1 (least pain) to 10 (most severe pain): _____

How Often Do You Get This Pain? _____ Is It Constant? _____

Type Of Pain: Sharp Dull Throbbing Numbness Aching Shooting
 Burning Tingling Cramps Stiffness Swelling Stabbing Other

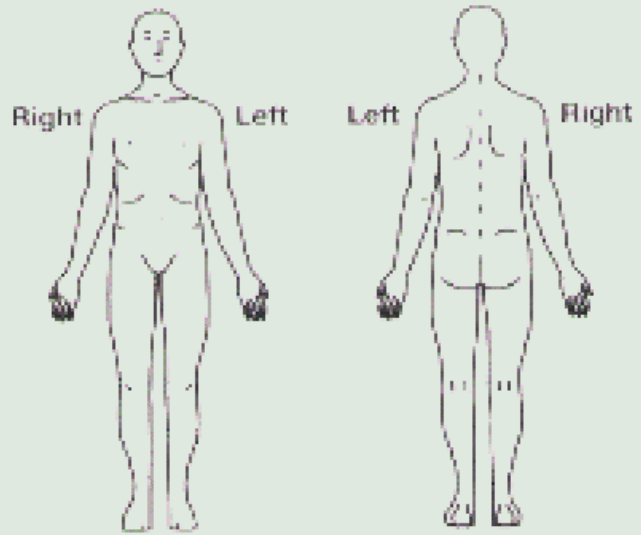
Does The Pain Interfere with Your: Work Daily Routine Recreation

Activities That Are Painful To Perform: Sitting Standing Walking Bending Lying Down

PAIN DIAGRAM

Mark An "X" On The Diagram To The Left To Mark Your Areas Of Pain, Numbness or Tingling.

Note Any Concerns You Have Or Additional Symptoms You Are Having: _____



To The Best Of My Knowledge The Above Information Is Complete & Correct. I Understand That It Is My Responsibility To Inform My Doctor If I, Or My Minor Child, Ever Have A Change In Health.

Signature Of Patient, Parent, Guardian or Personal Representative

Date

Please Print Name Of Patient, Parent, Guardian or Personal Representative

Relationship To Patient