DEBLON CHIROPRACTIC OFFICES

ACCIDENTAL INJURY FORM

DATE OR ACCIDENT:________________HOUR:____AM____PM
LOCATION:____

HOW DID ACCIDENT HAPPEN?: AUTO______WORK______OTHER______

DESCRIBE WHAT HAPPENED____
____

WAS INJURY REPORTED? Y N ; TO WHOM?____________________
{CIRCLE} POLICE OFFICER, FOREMAN, EMPLOYER, OTHER___________

AUTO ACCIDENT: WERE YOU THE DRIVER, PASSENGER, PEDESTRIAN

WERE YOU STRUCK FROM; BEHIND, RIGHT SIDE, LEFT SIDE, FRONT, AUTO WAS PARKED.
DID YOUR CAR STRIKE OTHERS? Y N

THE EXTENT OF THE INJURIES AS YOU KNOW THEM_________________
____

DID YOU REQUIRE HOSPITALIZATION? Y N ,WHERE?______________

CIRCLE OFF ALL SYMPTOMS SINCE THE ACCIDENT:

headache	irritability	numbness in toes	face flushed	feet cold
neck pain	chest pain	shortness of breath	buzzing in ears	hands cold
neck stiff	dizziness	fatigue	loss of balance	stomach upset
sleep problems	heavy head	depression	fainting	constipation
back pain	pins and needles in arms		light hurts eyes	cold sweats
nervousness	pins and needles in legs		memory loss	fever
tension	numbess in fingers or toes		ringing in ears	loss of smell
loss of taste	diarrhea	other______________________		

HAVE YOU LOST ANY DAYS OF WORK? Y N ; DATES:__________________
INSURANCE COMPANY____
HAVE YOU BEEN CONTACTED BY ANYONE SINCE THE ACCIDENT? Y N
CLAIMS ADJUSTERS NAME____

DO YOU HAVE A LAWYER INVOLVED ? Y N ; NAME:___________________
ADDRESS:______________________________PHONE#__________________