Schooley's Mountain
CHIROPRACTIC
Your Health in Our Hands
484 Schooley's Mountain Rd | Hackettstown, NJ 07840
o 908-852-6752 | f 908-852-5903

Print Patient Name: _____

File Number: _____

Auto Accident Case

(1) Was this accident reported to your insurance company? Yes _____ No _____

(2) Date of the accident: _____ (3) Claim#: _____

(4) Name of the policy holder: _____

(5) Policy Number: _____

(6) Please complete immediately, the PIP application that your auto insurance carrier mails to you, and bring it to our office. We will copy it for your file and mail it in for you.

(7) Most policies now require pre-certification of visits within a time frame, usually a 28-day cycle. It is important that you are aware of these time frames and keep your scheduled appointments within that time period.

(8) Insurance Company: Name: _____
Address: _____
Phone #: _____
Adjuster's Name: _____

(9) Because of privacy laws, your insurance company cannot provide us with your medical coverage (deductible and coverage amount). Please contact them regarding this information and provide it to our office as soon as possible so that we can set up your account.

I fully understand that the above information is necessary for this office to properly submit my bills. I am also aware that I am totally responsible for any charges I incur, if for any reason my insurance company refuses to pay. Most policies are subject to a deductible and co-payment and I am aware that I will be responsible for payment of these at time of service.

_____ Date

_____ Patient Signature

_____ Parent/Guardian Signature

PATIENT'S REPORT OF ACCIDENT

Name _____ Date _____

Location of accident _____ City _____

Date of accident _____ Time _____ Was police report made? _____

Were you: ☐ Driver ☐ Passenger Were you wearing seatbelts? _____

Were you struck from: ☐ Behind ☐ Right side ☐ Left side ☐ Front

Direction of your travel _____ Other car _____ Approximate speed of your car _____ Other car _____

Kind of car you were in _____ Approximate Damages $ _____ Other car _____ Approximate Damages $ _____

How did the accident occur? _____

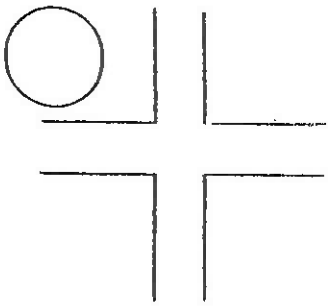
_____

_____

_____

Indicate on diagram what happened

INDICATE NORTH BY ARROW



How did you feel immediately after the accident? If the injury was not noticeable right away, when did you notice any problems? _____

_____

_____

_____

Have you received first aid or any other treatment for this injury? _____

If yes, from whom? _____ City _____

Were you hospitalized? _____ If yes how long? _____ Name and city of hospital _____

Were you off work because of this injury? _____ If yes, the first day you were unable to work _____

Have you returned to work? _____ If yes, on what date? _____

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ACCIDENT REPORT

Name: _____ Date of Accident _____ Time of Accident _____ am / pm
Type of injury: auto - work injury - fall - other _____
Where did accident happen, in detail _____

Did weather (ice, snow, rain or lightning, etc) play any part in accident? _____
Describe your symptoms in detail: (**circle all that apply**)

1) GENERAL SYMPTOMS:
nervousness · loss of sleep
irritability · tension
fatigue · PMS
depression · Jaw pain

2) HEAD:
headache: ☐ mild ☐ moderate ☐ severe
how often _____ times per ☐ day ☐ week ☐ month
are they ☐ sharp ☐ dull ☐ constant ☐ intermittent
where located
☐ back of head ☐ forehead ☐ temples
☐ right side ☐ left side ☐ behind eyes
light headed · sensitivity to light
memory loss · loss of balance
blurred vision · hearing loss
double vision · ringing in ears

3) NECK:
pain: ☐ left side ☐ right side ☐ both ☐ mild ☐ moderate ☐ severe
increased by forward movement
backward movement
rotation of head (right/left)
bending of neck (right/left)
stiffness
muscle spasm
grinding/grating sounds

4) SHOULDERS:

pain in joint	☐ left	☐ right	☐ both
pain across shoulder	☐ left	☐ right	☐ both
limitation of movement	☐ left	☐ right	☐ both
tension	☐ left	☐ right	☐ both

5) ARMS:

upper arm			
pain	☐ left	☐ right	☐ both
pins & needles	☐ left	☐ right	☐ both
numbness	☐ left	☐ right	☐ both
elbow pain	☐ left	☐ right	☐ both
forearm			
pain	☐ left	☐ right	☐ both
pins & needles	☐ left	☐ right	☐ both
numbness	☐ left	☐ right	☐ both

6) HANDS:

wrist pain	☐ left	☐ right	☐ both
hand			
pain	☐ left	☐ right	☐ both
pins & needles	☐ left	☐ right	☐ both
numbness	☐ left	☐ right	☐ both

7) MIDBACK:

pain	☐ left	☐ right	☐ both
	☐ mild	☐ moderate	☐ severe
spasm	☐ left	☐ right	☐ both
	☐ mild	☐ moderate	☐ severe

8) CHEST:

chest pain	☐ left	☐ right	☐ both
	☐ mild	☐ moderate	☐ severe
rib pain	☐ left	☐ right	☐ both
shortness of breath			
irregular heartbeat			

9) ABDOMINAL SYMPTOMS:

pain	☐ left	☐ right	☐ both
nervous stomach			
nausea			
gas			
constipation			
diarrhea			
heartburn			
indigestion			
loss of appetite			

10) LOWBACK:

pain	☐ left	☐ right	☐ both
spasm	☐ left	☐ right	☐ both

11) HIPS AND LEGS:

pain in buttocks	☐ left	☐ right	☐ both
	☐ mild	☐ moderate	☐ severe
pain in hip(s)	☐ left	☐ right	☐ both
	☐ mild	☐ moderate	☐ severe
pain down leg(s)	☐ left	☐ right	☐ both
	☐ mild	☐ moderate	☐ severe
knee pain	☐ left	☐ right	☐ both
	☐ mild	☐ moderate	☐ severe
leg cramp	☐ left	☐ right	☐ both

12) FEET:

ankle pain/swelling	☐ left	☐ right	☐ both
foot pain/cramps/ numbness/swelling	☐ left	☐ right	☐ both

Are your symptoms (1) getting worse, (2) improving, (3) same?
Have you seen another doctor for these symptoms? _____ If so, name and address _____ phone _____
Did you have any of these symptoms prior to this injury? _____ If so, please explain _____

Describe previous injury _____

_____ Doctor consulted _____

Time missed from work for previous injury _____

For present injury, have you missed any work? _____ If yes, dates missed _____

Dates of limited work _____ Date returned to full work _____

Were you capable of working on an equal basis prior to this present injury? _____

Are you right or left handed (circle one)? If married, is your spouse employed? Yes / No

If the present injury was due to an **auto accident**, were you the driver, passenger front, passenger back, or pedestrian?

other _____

Were you wearing a seatbelt?

Type of vehicle: auto, truck, van, motorcycle, motorhome, bicycle (other_____)

How accident occurred: **A)** struck by another vehicle **B)** struck another vehicle **C)** struck a stationary object

D) other _____

Where was your vehicle hit? **A)** front **B)** rear **C)** right side **D)** left side **E)** right front **F)** left front **G)** right rear **H)** left rear

Your approximate speed _____ MPH Other vehicle's approximate speed _____ MPH

What occurred at moment of impact? (circle as many as apply)

tensed body for impact	neck whipped forward & back	spine torqued and twisted	thrown over seat
thrown from vehicle	pinned in vehicle	thrown from side to side	cut and bruised

Did you strike your....

head	(against dash, windshield, steering wheel, right door, left door, seat frame, other)
shoulder	left/right (dash, windshield, steering wheel, right door, left door, seat frame, other)
arm	left/right (dash, windshield, steering wheel, right door, left door, seat frame, other)
elbow	left/right (dash, windshield, steering wheel, right door, left door, seat frame, other)
wrist	left/right (dash, windshield, steering wheel, right door, left door, seat frame, other)
hip	left/right (dash, windshield, steering wheel, right door, left door, seat frame, other)
knee	left/right (dash, windshield, steering wheel, right door, left door, seat frame, other)
ankle	left/rightt (dash, windshield, steering wheel, right door, left door, seat frame, other)

Were you rendered unconscious? yes/no Did you receive medical attention at scene? _____

Where did you go immediately following accident? hospital - home - doctor - this office - resumed regular activities

Comments

_____

_____

_____

By signing below, I acknowledge that the information given above is true to the best of my knowledge.

_____ _____

Signature Date