

**ACCIDENT/INJURY FORM**



HORNBACK CHIROPRACTIC  
 ■■■ & WELLNESS, P.A. ■■■

NAME \_\_\_\_\_ DATE \_\_\_\_\_

Date of Accident \_\_\_\_\_ Time: \_\_\_\_\_ am/pm Location of Accident \_\_\_\_\_

**AUTO INJURY**

Were You: ( ) Driver ( ) Passenger [( ) Front ( ) Right Rear ( ) Left Rear] ( ) Pedestrian

Were you struck from: ( ) Behind ( ) Right Side ( ) Left Side ( ) Front ( ) Parked

Did your car strike the others involved: ( ) Yes ( ) No ( ) Undetermined

Did the other car strike yours: ( ) Yes ( ) No ( ) Undetermined

Were you wearing your seatbelt? ( ) Yes ( ) No

Did you strike anything in the vehicle at the time of impact? ( ) Yes ( ) No

If yes what? \_\_\_\_\_

Traffic Conditions: ( ) Heavy/Congested ( ) Normal ( ) Rush Hour

Weather Conditions: ( ) Normal ( ) Raining ( ) Foggy ( ) Poor visibility

Vehicle Information (Make and Model): \_\_\_\_\_

As a result of the Accident, were traffic citations issued to you? ( ) Yes ( ) No

Location after the accident: ( ) Home ( ) Hospital ( ) Minor ER (Walk-in clinic)

Have you lost any days of work? ( ) Yes ( ) No If Yes, \_\_\_\_\_ through \_\_\_\_\_

Describe the accident: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**ON-THE-JOB INJURY**

How did the injury occur? \_\_\_\_\_

Did you report the injury to your foreman or employer: ( ) Yes ( ) No

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

**OTHER**

Describe the circumstances of the accident (Be Specific) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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**CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT**

- |                  |                            |                        |                   |
|------------------|----------------------------|------------------------|-------------------|
| ( ) Headache     | ( ) Sleeping Problems      | ( ) Lights Bother Eyes | ( ) Diarrhea      |
| ( ) Neck Pain    | ( ) Head Too Heavy         | ( ) Loss of Memory     | ( ) Feet Cold     |
| ( ) Neck Stiff   | ( ) Pins & Needles in Arms | ( ) Ears Ringing       | ( ) Hands Cold    |
| ( ) Dizziness    | ( ) Pins & Needles in Legs | ( ) Face Flushed       | ( ) Stomach Upset |
| ( ) Back Pain    | ( ) Numbness in Fingers    | ( ) Buzzing in Ears    | ( ) Constipation  |
| ( ) Nervousness  | ( ) Numbness in Toes       | ( ) Loss of Balance    | ( ) Cold Sweats   |
| ( ) Tension      | ( ) Shortness of Breath    | ( ) Fainting           | ( ) Fever         |
| ( ) Irritability | ( ) Fatigue                | ( ) Loss of Smell      | ( ) Other         |
| ( ) Chest Pain   | ( ) Depression             | ( ) Loss of Taste      | _____             |

**INSURANCE INFORMATION**

Your Insurance Company \_\_\_\_\_ Address \_\_\_\_\_

Have you been contacted by an insurance adjustor regarding this claim? ( ) Yes ( ) No

If yes, name of adjustor \_\_\_\_\_ Phone Number \_\_\_\_\_

Claim Number: \_\_\_\_\_

Do you have an attorney that has advised you in this case? ( ) Yes ( ) No

If yes, attorney's name \_\_\_\_\_ Address \_\_\_\_\_

Phone Number: \_\_\_\_\_

Signature \_\_\_\_\_