QUAIL VALLEY CHIROPRACTIC ACCIDENT FORM

Name:_____ Address:_____

Date of accident:_____Hour:_____am/pm Location:_____

Was the accident work related (company vehicle)? Yes / No Were you in a rental car? Yes / No

If this was work related, did you report it to your supervisor: Yes / No Name:_____

Were you the (circle one): Driver Passenger Pedestrian

Describe the accident:_____

_____

Did you have your seat belt on? Yes No

Were you struck from (circle one)?: Behind Right Left Rear

Did you strike others?: Yes No Were tickets issued (circle one)?: Self Other Driver(s)

Describe your symptoms you have been experiencing since the accident:_____

_____

Did you seek immediate medical attention (ER, etc.)?: Yes No Location: _____

Please check off the symptoms that apply to you since the above listed accident:

___Headache	___Dizziness	___Depression	___Fatigue
___Stomach Upset	___Light sensitive	___Buzzing in ears	___Diarrhea
___Neck Pain/Stiff	___Head feels heavy	___Memory Loss	___Feet Cold
___Fainting	___Arm(s) Tingle	___Ears Ring	___Hands Cold
___Face Flushed	___Sleeping Problems	___Loss of Balance	___Back Pain
___Nervousness	___Legs Tingle	___Constipation	___Tension
___Irratability	___Fingers Numb	___Loss of Smell	___Fever
___Cold Sweats	___Shortness of Breath	___Loss of Taste	___Chest Pain

Have you lost days of work?: Yes No Starting Date of absence: _____

Have your opened your Personal Injury Protection Insurance from your auto policy (PIP)?: Yes No

List other insurance companies involved: _____

Have you been contacted by an Insurance Adjuster or Representative for this accident? Yes No

Have you retained an attorney? Yes No Name:_____ Phone#:_____

List the Year, Model, and Make of the car your were in: _____

Signature:_____ Date:_____