EAGLE CHIROPRACTIC SHAWN H NORD DC

5337 W. State St. Eagle, ID 83616 Phone# (208)939-9195 Fax#(208)939-4686

AUTO RELATED ACCIDENT

Date and time of Accident:_____ ___ am ___ pm, Were you the: ___ Driver __ Front pass. __ Rear pass

If a traffic violation was issued, to whom was it issued? _____Number of people in accident vehicle? _____

Did the police come to the accident site? ___ Yes ___ No, Was a police report filed? ____ Yes ____ No

Were there any witnesses? ____ Yes ____ No _____

Were you wearing your seat belt? ____ Yes ____ No, Was the vehicle equipped with air bags? ___ Yes ___ No

Did they inflate? ____ Yes ____ No

In the relation to the base of your skull, where was the headrest? ____ above _____ below _____ base of skull

What did your vehicle impact? ___ another vehicle ___ other? _____

Did any part of your body strike anything in the vehicle? ___ Yes ___ No, If yes, please describe:_____

Make and Model of the vehicle you were occupying? _____

What was the approx. speed of your vehicle? _____ In which direction were you headed? __ N __ S __ E __W

Name of location/street on which you were traveling? _____

Did the impact to your vehicle come from the: ___ Front ___ Rear ___Right side ___ Left side

During impact, were you facing: __ right __ left __ forward? Were you __ aware of __ surprised by the impact?

If accident vehicle made impact with another vehicle?

Make and model of that other vehicle? _____

Direction the other vehicle was headed? __ N __ S __ E __ W? Speed of other vehicle? _____

In your words, please describe the accident: _____

_____

AT FAULT AUTO INSURANCE INFORMATION

Co. Name and address _____
Phone # _____ Group (Plan, Local or Policy) # _____
Insured's Name _____ Relationship to driver: _____
Date of birth of insured: _____ Insured's Employer: _____

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AFTER INJURY

Did the accident render you unconscious?___ Yes ___ No. If yes, for how long? _____

Please describe how you felt immediately after the accident: _____

Have you gone to a Hospital or seen any other Doctor? ___ Yes ___ No

When did you go? ___ just after the accident ___ the next day ___ 2 days plus

How did you get there? ____ Ambulance ____ Private transportation

Name of Hospital and/or Attending Physician: _____

Describe any treatment you received: _____

Were X-rays taken? ___ Yes ___ No, Was medication prescribed? ___ Yes ___ No

Have you been able to work since this injury? ___ Yes ___ No, Is your work restricted as a result of this injury?____

Indicate **X** the symptoms that are a result of this accident? __ Dizziness __ Difficulty sleeping __ Jaw problems

__ Nausea __ Memory loss __ Irritability __ Arm/shoulder pain __ Back pain __ Back stiffness __ Headaches

__ Fatigue __ Numb hand/fingers __ Lower back pain __ Blurred vision __ Tension __ Chest pain

__ Neck pain __ Neck stiffness__ Buzzing in ear __ Shortness of breath __ Leg pain __ Ears ringing

__ Stomach upset __ Numb feet/toes __ Other? _____ Is your condition getting worse? __ Yes __ No

Indicate your degree of comfort while performing the following activities:

	Comfortable / Uncomfortable / Painful				Comfortable / Uncomfortable / Painful		
Lying on back				Sports			
Lying on side				Working			
Lying on stomach				Lifting			
Sitting				Bending			
Standing				Kneeling			
Stretching				Pulling			
Running				Reaching			

RECOVERY

To evaluate the effect that continuing work will have on your recovery please complete the following:

How many hours are in your normal workday? _____

Please indicate **X** your daily job duties and any activities which you are occasionally asked to perform:

__ Standing __ Driving __ Operating equipment __ Sitting __ Twisting __ Walking __ Crawling __ Typing

__ Lifting__ Working with arms above your head __ Bending __ Stooping __ Other? _____

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Are there positions can you work in with minimum physical effort and for how long? _____

Prior to injury were you capable of working on an equal basis with others your age? _____

Do you work with others who can help you with any heavy lifting? _____

While in recovery, is there any light duty work you could request? _____

ADDITIONAL INSURANCE INFORMATION

Type of insurance: _____ Co Name & Address _____

Phone # _____ Insured's Name & Address _____

Relationship: _____Policy # _____ Claim # _____

Insured's SS# _____ D.O.B.: _____ Insured's Employer _____

Please remember you are ultimately responsible for your account.

Signature: _____ Date _____

Notes: