PARAMOUNT CHIROPRACTIC
-Family Wellness-

PATIENT INFORMATION

Name: _____ (Age) _____ Gender: M F

Home Address: _____ Cell Phone: ( ) _____

City, State, Zip: _____ Home Phone: ( ) _____

Email Address: _____ Work Phone: ( ) _____

Birth Date: _____ / _____ / _____ Social Security #: _____ - _____ - _____ Marital Status: S M D W

Names of Children: _____ Ages: _____

Females only: Pregnant: Yes / No Estimated due date: _____

Occupation: _____ Employer Name: _____

Spouse's Name: _____ Cell Phone: ( ) _____ Work Phone: ( ) _____

Spouse's Employer: _____ Occupation: _____

How were you referred to this office? _____

INSURANCE INFORMATION

Patient's Car Ins. Company: _____ Ins. Phone #: _____

Claim #: _____ Name of policy holder:_____

Adjuster's name:_____ Adjuster's phone number:_____

PIP insurance available: ☐ Yes ☐ No

Insurance company of other vehicle involved: _____ Ins. Phone #: _____

Claim #: _____ Name of policy holder:_____

Adjuster's name:_____ Adjuster's phone number:_____

Policy: _____

ACCIDENT INFORMATION

Date of accident: _____ Time of accident: _____

Driver of car: _____ Where were you seated:_____

Who owns the car:_____

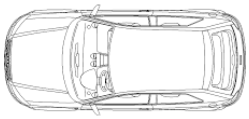
Year and model of your car:_____

Year and model of other car:_____

What was the approximate amount of damage done to your car:_____

Visibility at the time of accident: ☐ Poor ☐ Fair ☐ Good ☐ Other _____

Road conditions at time of accident: ☐ icy ☐ rainy ☐ wet ☐ clear ☐ dry ☐ other: _____

Where was the car struck: FRONT  REAR

In your own words, please describe the accident: _____

_____

_____

Illustrate how the accident happened:

Type of collision: ☐ Head-on ☐ Broad-side ☐ Front impact ☐ Rear end of car in front ☐ Rear impact ☐ Non-collision

At the time of the accident, what part of your head or body parts hit the inside of the car? _____

Did you see the accident coming: ☐ Yes ☐ No Did you brace for impact: ☐ Yes ☐ No

Did you have your seatbelt on: ☐ Yes ☐ No Did your seatbelt have a shoulder harness that was on: ☐ Yes ☐ No

Does your car have headrests: ☐ Yes ☐ No

If yes, what position was the headrest in compared to your head: ☐ Top of headrest even with bottom of head

☐ Top of headrest even with top of head ☐ Top of headrest even with middle of head

Was your car braking: ☐ Yes ☐ No Was your car moving at the time of impact: ☐ Yes ☐ No

If yes, estimate of how fast you were going _____mph The speed of the other car _____ mph

Head/body position at time of accident: ☐ Head turned left or right ☐ Head looking back ☐ Head straight forward

☐ Body straight in sitting position ☐ Body rotated left or right ☐ Other:_____

As a result of the accident were you: ☐ Rendered unconscious ☐ In shock ☐ Dazed, circumstances vague ☐ Other: _____

How was the shoulder harness adjusted: ☐ Loose ☐ Snug

Were you wearing a hat or glasses: ☐ Yes ☐ No

Could you move all parts of your body ☐ Yes ☐ No

If no, what parts could you not move and why: _____

Were you able to get out of the car and walk unaided: ☐ Yes ☐ No If not, why not:_____

Did you get any bleeding cuts: ☐ Yes ☐ No If yes, where:_____

Did you get any bruises: ☐ Yes ☐ No If yes, where:_____

Describe how you felt immediately after the accident:_____

Later that day:_____

The next day:_____

Check the symptoms apparent since the accident:

☐ Headache	☐ Chest pain	☐ Neck pain/stiffness	☐ Mid-back pain	☐ Light sensitivity
☐ Light sensitivity	☐ Pain behind ears	☐ Dizziness	☐ Low-back pain	☐ Sleeping problems
☐ Diarrhea	☐ Loss of smell	☐ Numbness in toes	☐ Fainting	☐Cold feet
☐ Facial pain	☐ Loss of memory	☐ Fatigue	☐ Breath shortness	☐ Lost of taste
☐ Irritability	☐ Depression	☐Ringing/buzzing	☐ Cold sweats	☐ Loss of balance
☐ Tension	☐ Constipation	☐ Cold hands	☐ Clicking/popping of jaw	☐ Numbness in fingers

☐ Other:_____

Have you missed time from work: ☐ Yes ☐ No

If yes, full time off of work _____ to _____

If yes, part time off of work _____ to _____

Did you seek medical care immediately after accident: ☐ Yes ☐ No

If yes, how did you get there: ☐ Ambulance ☐ Police ☐ Someone drove me ☐ Drove myself ☐ Other:_____

Doctor #1:_____ First visit date:_____

Were you examined: ☐ Yes ☐ No X-rays taken: ☐ Yes ☐ No

Did you receive treatment: ☐ Yes ☐ No ☐ Medication ☐ Braces ☐ Collars

If yes, what kind of treatment did you receive: _____

What benefits did you receive from treatment: _____

Date of last treatment:_____

Doctor #2:_____ First visit date:_____

Were you examined: ☐ Yes ☐ No X-rays taken: ☐ Yes ☐ No

Did you receive treatment: ☐ Yes ☐ No ☐ Medication ☐ Braces ☐ Collars

If yes, what kind of treatment did you receive: _____

What benefits did you receive from treatment: _____

Date of last treatment: _____

Do you have an attorney for this claim: ☐ Yes ☐ No

If yes, name of attorney: _____ Name of firm:_____

Address: _____City/St_____ Zip_____

Phone: _____