Chiropractic Wellness Center
2915 E Baseline Rd #126
Gilbert, Arizona 85234

Name_________________________________ Today's Date________________ Date of accident__________

If this was an auto accident, were you the: Driver Passenger Pedestrian

If auto collision, were you struck from: Behind Right side Left side Front Auto was parked
Other____

Did your car strike the other(s) involved? Yes No

Did the other car strike yours? Yes No

Were traffic tickets issued? Yes No
If yes please provide copy of citation

Did any part of your body strike any part of the car Yes No
If yes please explain____
____

Did you have your seat belt on? Yes No

Did the car have a headrest? Yes No

Height or position of the headrest? Shoulder Neck Head Above Head

Loss of consciousness? Yes No
If yes, please explain____

Were you stunned? Yes No
If yes, how long?____

Did you feel or hear popping, tearing, or a ripping noise in your neck or back? Yes No
If yes, please explain____

Did you feel any pain? Yes No
If yes, where?____

How long after the accident did you feel pain?____

Do you have any bruises? Yes No
If yes, where?____

Do you have any swelling? Yes No
If yes, where?____

Did you require post accident care or hospitalization? Yes No
If yes, where?____

Were you examined? Yes No

If yes, by whom?____

Were you x-rayed? Yes No

Was any treatment given? (medication, supports or recommendations)

____

What is your occupation?______________________________________

What duties are required of you on the job?____________________

Have you missed work as a result of the accident? Yes No

If yes, how many days?____

If no, do you experience pain while working? Yes No

Do you have difficulty with prolonged/excessive:

Riding in a car Bending Standing Sitting Walking Lifting Twisting/Turning

Please circle symptoms you have experienced since the accident

Headache	Low back pain	Tremors	Constipation
Skull or head pain	Low back stiffness	Face flushed	Excessive perspiration
Neck stiffness	Hip pain	Neck pain	Loss of perspiration
Head feels too heavy	Buttock pain	Dizziness	Loss of taste
Shoulder pain	Leg pain	Fainting	Cold sweats
Shoulder stiffness	Leg numbness	Sinus trouble	Fever
Arm pain	Pins and needles in legs	Loss of smell	Swelling, if so where
Arm numbness	Numbness in feet/toes	Eye strain	Chest pain
Pins and needles in arm	Cold feet	Difficulty focusing	Rib pain
Numbness in hands/fingers	Depression	Pain behind eyes	Painful breathing
Cold hands	Anxiety	Eyes sensitive to light	Shortness of breath
Upper back pain	Tension	Double vision	Difficulty sleeping
Upper back stiffness	Irritability	Buzzing/ringing in ears	Fatigue
Mid back pain	Nervousness	Loss of balance	Digestive problems
Mid back stiffness	Mental Dullness	Palpitations	Nausea

Details of Impact

Time of accident____________ AM PM Weather conditions____

Road conditions____

Street(s)____

Patient headed (N S E W) Other vehicle(s) headed (N S E W)

Patient's speed _________________ Other vehicle(s) speed ___________________

Patient's car type__________________________ Other vehicle(s) car type ___________________________

Was your body Straight Bent Twisted Was your head Neutral Up Down

Did you have the brake on? Yes No

Were you aware of the impact? Yes No

Insurance Information

Your insurance company____

Address____City________________

State_____________ Zip_____________

Phone #___________________________________ Adjuster_______________________________________

Policy #____

Do you have med pay? Yes No

Please provide us with a copy of your car insurance card

Insurance of person responsible for the accident____

Address____ City________________

State_________________ Zip___________

Phone #________________________________ Adjuster___________________________

Claim # ____

PLEASE PROVIDE US WITH A COPY OF POLICE REPORT!!

Do you have an attorney for this personal injury case? Yes No

If yes, please fill out below

Your attorney's firm____

Attorney's Name____

Address____________________________________ City___________________ State______Zip___________

Phone #____

Dear Patient,
Welcome to our Chiropractic Wellness Center. We are sad to hear that you have been involved in a personal injury claim and you have come to the right place to receive excellent care for your recovery. There are a few details that are important as you begin care.

- Required information:
    1. Party at fault's name
    2. Insurance company
    3. Insurance company's phone number
    4. Adjustor's name
    5. Medical Claim number. It is very important for us to receive the claim number on your first day of treatment.

- Med Pay
    1. Copy of your car insurance card
    2. Copy of your drivers license
    3. Med Pay claim #

- On your first appointment we will be gathering a lot of information and documenting all injuries. This process may take up to two hours.

- After reviewing all of your information, the doctor will determine a care plan including of number of visits per week necessary and other therapies that may assist in your healing. We ask that you comply with your care plan and attend all appointments. This also determines how serious the insurance company will take your claim. We understand that life can be hectic and you may need to reschedule at times; please give us 24 hours notice of cancellation.

- Every 12 visits the doctor will do a re-exam to assess your progress. These visits will take approximately one hour. With every re-exam, there will be additional paperwork for you to complete. It is very important that it is completed during this visit.

- As a courtesy to you, we will wait for payment until your case is closed and the doctor has released you from care. All of your medical records and itemized statement will be sent to the insurance company or to your attorney. With every personal injury case, to ensure payment for your treatment, a lien will be filed.

- You may be covered under your personal car insurance with Med Pay. This is an added medical benefit to your policy. It is there for you to use to pay medical bills promptly and we will bill them directly. Using your Med Pay will not raise your rates. If you have any questions about Med Pay, please ask us.

I have read and fully understand the Chiropractic Wellness Center's personal injury policies.

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Signature   date