# MOTOR VEHICLE ACCIDENT HISTORY

| PATIENT NAME: | | | DATE: |
|---|---|---|---|
| ADDRESS: | | CITY: | STATE/ZIP CODE: |
| HOME PHONE NUMBER: | | CELL PHONE NUMBER: | |
| SOCIAL SECURITY NUMBER: | DATE OF BIRTH: | AGE: | GENDER: |
| EMERGENCY CONTACT NAME: | | EMERGENCY CONTACT PHONE NUMBER: | |
| EMPLOYER NAME: | | EMPLOYER ADDRESS: | |
| EMAIL: | | | |

## ACCIDENT INFORMATION

| DATE OF ACCIDENT: | TIME OF ACCIDENT: | WHERE WERE YOU LOCATED IN THE VEHICLE AT THE TIME OF THE ACCIDENT?<br>❑ DRIVER ❑ PASSENGER ❑ FRONT SEAT ❑ BACK SEAT | |
|---|---|---|---|
| NUMBER OF PEOPLE IN THE CAR: | NAMES OF PEOPLE IN THE CAR WITH YOU: | | |
| WHAT DIRECTION WAS YOUR CAR HEADED?<br>❑ NORTH ❑ SOUTH ❑ EAST ❑ WEST | | ON WHAT STREET WERE YOU HEADED? | |
| WHAT DIRECTION WAS THE OTHER CAR HEADED?<br>❑ NORTH ❑ SOUTH ❑ EAST ❑ WEST | | WERE YOU STRUCK FROM:<br>❑ BEHIND ❑ FRONT ❑ LEFT SIDE ❑ RIGHT SIDE | |
| WERE YOU KNOCKED UNCONSCIOUS?<br>❑ YES ❑ NO | | DID YOU HIT YOUR HEAD?<br>❑ YES ❑ NO | |
| WHERE WERE YOU TAKEN AFTER THE ACCIDENT? | | | BY AMBULANCE:<br>❑ YES ❑ NO |
| WERE THE POLICE ON THE SCENE?<br>❑ YES ❑ NO | WAS A REPORT FILED?<br>❑ YES ❑ NO | DO YOU HAVE A COPY?<br>❑ YES ❑ NO | |
| HAVE YOU BEEN TREATED BY ANY OTHER DOCTORS FOR THIS INJURY/ACCIDENT?<br>❑ YES ❑ NO | | SINCE THE INJURY, ARE YOUR SYMPTOMS:<br>❑ IMPROVING ❑ GETTING WORSE ❑ GETTING BETTER | |
| HAVE YOU LOST TIME FROM WORK?<br>❑ YES ❑ NO | | DATE YOU LEFT WORK: | DATE YOU RETURNED TO WORK: |
| HAVE YOU BEEN INVOLVED IN AN ACCIDENT IN THE PAST?<br>❑ YES ❑ NO | | IF YES, PLEASE DESCRIBE: | |
| DO YOU HAVE ANY PREVIOUS ILLNESSES WHICH RELATE TO THIS CASE?<br>❑ YES ❑ NO | | IF YES, PLEASE DESCRIBE: | |
| DO YOU HAVE ANY ACTIVITY RESTRICTIONS AS A RESULT OF THIS INJURY?<br>❑ YES ❑ NO | | IF YES, PLEASE DESCRIBE: | |

## INSURANCE INFORMATION

AUTO INSURANCE COMPANY NAME:

| ADJUSTER NAME: | ADJUSTER PHONE NUMBER: |
|---|---|
| POLICY NUMBER: | CLAIM NUMBER: |

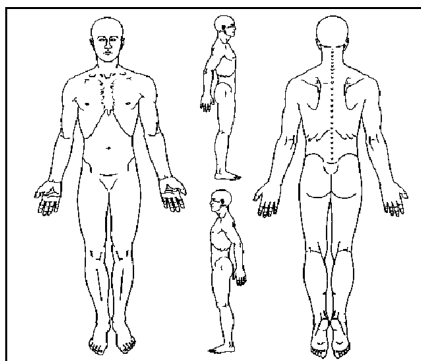
## SYMPTOMS

INSTRUCTIONS: *Check (✓) any/all symptoms noted after the accident.*

| | | |
|---|---|---|
| ❑ HEADACHE | ❑ DIZZINESS | ❑ LIGHT BOTHERS EYES |
| ❑ NECK PAIN | ❑ HEAD SEEMS HEAVY | ❑ LOSS OF MEMORY |
| ❑ NECK STIFFNESS | ❑ PINS & NEEDLES IN ARMS | ❑ EARS RING |
| ❑ SLEEPING PROBLEMS | ❑ PINS & NEEDLES IN LEGS | ❑ FACE FLUSHED |
| ❑ BACK PAIN | ❑ NUMBNESS IN FINGERS | ❑ BUZZING IN EARS |
| ❑ NERVOUSNESS | ❑ NUMBNESS IN TOES | ❑ LOSS OF BALANCE |
| ❑ TENSION | ❑ SHORTNESS OF BREATH | ❑ FAINTING |
| ❑ IRRITABILITY | ❑ FATIGUE | ❑ LOSS OF SMELL |
| ❑ CHEST PAIN | ❑ DEPRESSION | ❑ LOSS OF TASTE |
| ❑ DIARRHEA | ❑ FEET FEEL COLD | ❑ UPSET STOMACH |
| ❑ CONSTIPATION | ❑ HANDS FEEL COLD | ❑ OTHER: _______________ |
| ❑ FEVER | ❑ COLD SWEATS | ❑ OTHER: _______________ |

**INTRUCTIONS:** *Please mark the area and type of pain on the drawings using the codes listed below:*

N=Numbness P=Pain A=Ache T=Tingling S=Stiffness/Soreness



COMMENTS:

______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

PLEASE PROVIDE ANY OTHER PERTINENT INFORMATION YOU THINK WE SHOULD KNOW:

## DOCTOR ONLY

DOCTOR COMMENTS:

## SIGNATURE

| PATIENT SIGNATURE: | DATE: |
|---|---|

## NOTICE OF CANCELLATION POLICY

### CANCELLATION POLICY -- EFFECTIVE NOVEMBER 1, 2019

It is the policy of Family First Chiropractic Center to assess a $25 missed visit fee to patients who cancel appointments with less than a 5 hour notice. One missed visit will not result in the assessment for a fee, but you will be charged for any additional missed visits. This clinic provides care for many individuals and families, and missed visits result in time lost that could have been used to provide care for others.

My signature below indicates that I understand the above missed visit policy

SIGNATURE:_____________________________________________ DATE:__________________

### PAYMENT AUTHORIZATION -- EFFECTIVE NOVEMBER 1, 2019

My signature below states that I authorize Family First Chiropractic Center to process my cancellation fee within 30 days of the missed appointment. I agree to provide a credit/debit card to keep on my secure account for any future payments.

SIGNATURE:_____________________________________________ DATE:__________________

**Family First Chiropractic Center**
**11901 Hwy 65**
**Blaine, MN 55434**