NATURAL HEALTH PRACTICES
4904 Clyde Morris Blvd. Suite A, Port Orange, FL 32129
(386) 307-8207

AUTO ACCIDENT INFORMATION FORM

Full Name:	Social Security Number:
Mailing Address:	Apt #:
City and State:	Zip:
Email Address:	Phone:
Preferred primary method of contact (circle one): Email Phone Call Text Message	How did you hear about us?
Marital Status (circle one): Single Married Divorced Widowed	Name of Spouse:
Name and phone number of emergency contact:	Have you been seen for chiropractic care before?

Work status (circle one): Full-time Part-Time Unemployed Retired Other		Occupation and Employer:		
Date of Birth:	Sex: M / F	Height:	Weight:	Dominance: Right Left Both
Do you (circle all that apply): Use Tobacco Products Drink Alcohol		Race/Ethnicity:		
Current medications and nutritional supplements:		Major illnesses and surgeries (include out-patient or "routine" procedures) with approximate dates:		

Date of your accident:	Were you the driver, passenger, or pedestrian?
Your auto insurance company's name and adjuster's info:	Your auto insurance policy number:
Claim number:	Your attorney's name and phone number:
Make, model, and year of all vehicles involved in the accident (please specify which vehicle is yours):	
In your own words and with as much detail as possible, please describe the accident:	

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How many vehicles were involved in the accident?	Was your vehicle struck by another vehicle?
What type of impact occurred? (Circle one) Driver-Side Passenger-Side Rear Front	Where did the accident occur?
What time of day did the accident occur?	How were the driving conditions and weather like?
What direction were you headed? (Circle one) North East South West	How fast was each vehicle going at time of impact?
At impact, was your vehicle: (Circle one) Stopped Slowing down Speeding up	At impact, the other vehicle was: (Circle one) Stopped Slowing Down Speeding up
Did the vehicle hit another structure after the accident?	Did any part of your body strike anything in the vehicle?
Which foot was on the brake?	Which hand(s) were on the steering wheel?
Where were you looking at the time of impact?	Which position was the headrest in? Low Mid High
What air bags deployed?	Were you wearing a seatbelt?
Did all doors freely open after the accident?	Did the police arrive after the accident?
What treatments have you received for the accident (either at home or elsewhere)?	Where you seen for an exam since your accident? If so, where?

Have you experienced any of the following symptoms since your accident? (Circle all that apply)

Headache
Jaw/facial pain
Neck pain
Neck stiffness
Mid back pain
Mid back stiffness
Low back pain
Low back stiffness
Shoulder pain
Shoulder stiffness
Upper limb pain
Hands/fingers numbness or tingling
Lower limb pain
Feet/toes numbness or tingling
Muscle spasms

Constipation
Diarrhea
Nausea and/or vomiting
Anxiety
Depression
Difficulty swallowing
Chest pain
Ringing in the ears
Cold feet
Cold hands
Cold sweats
Dizzy/dazed/disoriented
Fainting
Fatigue

Impaired concentration
Sensitivity to noise
Sensitivity to light
Loss of balance
Loss of smell
Loss of taste
Irritability
Loss of memory/forgetfulness
Shortness of breath
Sleeping problems
Other:

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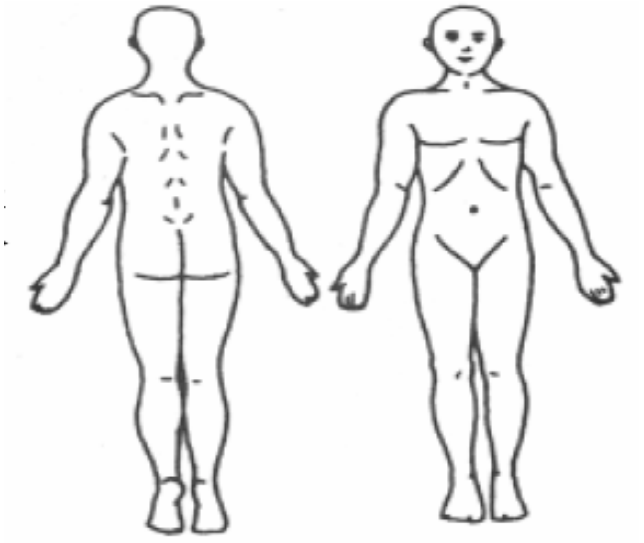
List your major health concerns arising from your car accident in order of severity (from most to least severe.)	How bad is it on a scale from 1-10? (10 is the worst)	Can you describe it? (Sharp, Dull, Tingling, etc...)	Is it worsening or improving since then?	Does anything make it better?	Does anything make it worse?
1.					
2.					
3.					
4.					
5.					

Please mark up this diagram indicating the location and type of symptoms you're experiencing.



The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Natural Health Practices. I understand that I am financially responsible for any balance. I also authorize Natural Health Practices and my insurance company to release any information to process my claims.

_____	_____	_____
Patient Name	Patient Signature	Today's Date