Linn City Chiropractic & Spinal Decompression

18750 Willamette Drive Suite F West Linn, OR 97068 (503) 908.0122 www.linncitychiro.com

Today's Date_____

Driver Information: (required)

Name_____ Date of Birth_____ Phone_____
Names of ALL passengers:
1. Front passenger_____ 3. L rear passenger_____
2. R rear passenger_____ 4.mid rear passenger_____

Your address_____ City_____ State_____ Zip _____
Your Ins. Co_____ Your Policy #_____ Agent's Name_____ Agent's Phone # _____
Year, Make, Model of your vehicle_____
Claim # from your Insurance Company _____

(if you have not done so, complete an application for Personal Injury Benefits)

Other Driver Information: (if you know)

Name_____ DOB(mm/dd/yyyy)_____ Phone_____
Ins. Co_____ Policy #_____
Agent's Name_____ Agent's Phone # _____
Year, Make, Model of other vehicle(s) _____
Claim # from their Insurance Company _____

Have you retained an attorney? ☐Yes ☐No
Name_____ Phone Number _____
Were there any witnesses? ☐Yes ☐No (if so, get a signed statement from them)
Name_____ Phone Number _____
Have you seen any other health care providers for this accident (Hospitals, ER, etc.)?
☐Yes ☐No List all providers seen, including hospitals, X-ray and MRI centers
Name_____ Location_____
Name_____ Location_____
Name_____ Location_____

Nature of Accident:

Date of Accident (do not estimate) _____ Time of Day_____ am/pm
☐Wet ☐Dry ☐Sunny ☐ Overcast ☐ Rain ☐ Foggy ☐ Dark ☐ Black Ice ☐ Snow
Address/cross street of accident_____ City_____ State____
Check all that apply: ☐Driver ☐Passenger ☐Motorcycle ☐Walking
☐Front Seat ☐Back Seat ☐Booster Chair ☐Car Seat ☐Seat-belted ☐Unseat-belted
Number of people in your vehicle?_____ ( ) Adults ( ) Minors ( ) Pets
What direction were you headed? ☐North ☐East ☐South ☐West on (name of street) _____
What direction was the other vehicle headed? ☐North ☐East ☐South ☐West on (name of street) _____
Were you struck from: ☐Behind ☐Front ☐Left side ☐Right side ☐Multiple strikes
Did you lose consciousness? ☐Yes How long?(___) mins ☐No ☐Maybe ☐Unknown

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Did your airbags deploy? ☐Yes ☐No Did the air bags strike you? ☐Yes ☐No
Was your car disabled? ☐Yes ☐No Was your car towed from the scene? ☐Yes ☐No
Were you taken to a hospital either by ambulance or take yourself? ☐Yes ☐No
Were police notified? ☐Yes ☐No Was the DMV notified? ☐Yes ☐No
(Report accidents with injuries to the DMV within 72 hours)

In your own words, please describe accident:

_____
_____
_____

Did you have physical complaints BEFORE THE ACCIDENT? ☐Yes ☐No If yes, please describe in detail:

_____
_____
_____

Please describe how you felt:

A. DURING the accident _____
B. IMMEDIATELY AFTER the accident _____
C. LATER THAT NIGHT: _____
D. THE NEXT DAY: _____

What are PRESENT complaints and symptoms?

_____
_____

Do you have any congenital (birth) factors which relate to this problem? ☐Yes ☐No
If yes, please describe_____

Do you have any previous illness which relate to this case? ☐Yes ☐No
If yes, please describe:_____

Have you ever been involved in an accident before? ☐Yes ☐No.
If yes, include mm/yyyy of accident, and injured areas. (if any)

_____
_____
_____

Where were you taken after this recent accident? _____

Have you seen another medical provider for this recent accident? ☐Yes ☐No
Doctor_____ Phone:_____ Treatment:_____
Doctor_____ Phone:_____ Treatment:_____
Doctor_____ Phone:_____ Treatment:_____

Have you lost time from work as a result of this accident? ☐Yes ☐No

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If yes, please complete these questions:

A. Last Day Worked: _____

B. Type of Employment: _____

C. Are you being compensated for time lost from work? ☐Yes ☐No

If yes, please state type of compensation you are receiving_____

Please describe ALL activity restrictions as a result of this accident:

_____

_____

Since this accident occurred, are your symptoms: ☐Improving ☐Getting Worse ☐Same

CHECK ALL SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

Head /Neck / Arms / Hands:

☐ Head seems heavy (739.0) ☐ Headache (784.0, 339.2) ☐ Facial Pain (767.5)
☐ Buzzing in ears (388.30) ☐ Dizziness (780.4) ☐ Irritability (799.22)
☐ Face Flushed (782.62) ☐ Loss of Balance (781.2) ☐ Loss of Smell (781.1)
☐ Loss of Memory (780.93) ☐ Loss of Appetite ☐ Loss of Taste (781.1)
☐ Neck Pain (723.1) ☐ Neck Stiff (739.1) ☐ Throat pain (784.1)
☐ Hands Cold (782.0) ☐ Numbness in Fingers (782.0)
☐ Pins & Needles in Arms (782.0)

Chest / Constitutional Symptoms: :

☐ Chest Pain (786.5) ☐ Shortness of breath (786.05)
☐ Fatigue (780.7) ☐ Stomach Upset (787.02) ☐ Depression (311.0)
☐ Fainting (780.2) ☐ Constipation (564.0) ☐ Cold Sweats (780.8)
☐ Nervousness (799.21) ☐ Fever (780.6) ☐ Tension (728.85)
☐ Ears Ring (388.30) ☐ Diarrhea (787.91) ☐ Swelling (782.3)(783.0)
☐ Vomiting (787.03) ☐ Stress (308.80)
☐ Sleeping Problems (780.50)
☐ Lack of Coordination (781.3)
☐ Sleeping Problems (780.50)
☐ Excessive sweating (780.8)

Back / Legs / Feet:

☐ Back Pain (724.2) ☐ Stiff Back (739.2) ☐ Sciatica (724.3)
☐ Feet Cold (782.0) ☐ Numbness in toes (782.0) ☐ Radiating leg pain (724.3)
☐ Pins & Needles in Legs (782.0)
Additional Symptoms not reported:_____