AUTO ACCIDENT

DR. USE ONLY
H.R.:_____
B.P.:___/___
Weight:_____

BONT CHIROPRACTIC

Patient #___ ___ _____

Date: _____

Patient Name:_____ S.S.#:_____
Address:_____ City: _____State: _____Zip:_____
Birthday: _____Sex:_____ Marital Status:_____ Spouse's Name:_____
Home #:_____ Cell #:_____
Work #:_____ Email:_____
Occupation:_____ Employer:_____
Emergency Contact:_____ Relationship:_____ Phone #:_____
How were you referred to our office? _____

Your Insurance Co._____Policy#_____
Claim#:_____Adjuster's Name: _____Phone #_____
Please explain, in detail, how your accident happened: _____
_____
_____
Driver of other vehicle, if any: _____
Other Driver's Ins. Co:_____Phone #_____
Address: _____Policy #:_____Claim#_____

Have you retained an attorney? □ Yes □ No □ Not Yet □ Other: _____
If so, attorney's name, address and phone: _____

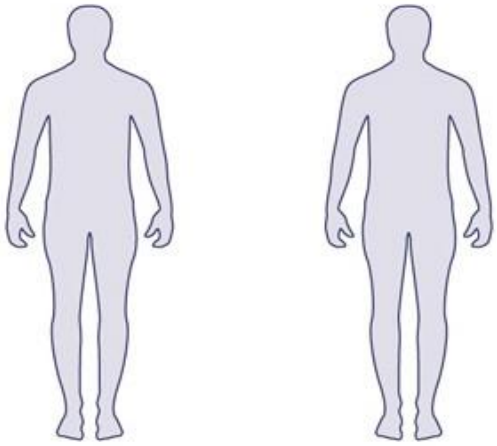
Time and Date present injury occurred: ____:____ □ AM □ PM **on** _____/_____/_____ *(mm/dd/yy)*
You were heading? □North □South □East □West **on** _____ *(street/highway)*
Number of people in your vehicle? _____ Were police notified? □ Yes □ No
Were you knocked unconscious? □ Yes □ No Did head strike the windshield or object? □ Yes □ No
You were struck from? □ Behind □ Front □ Left Side □ Right Side □ Other_____
You were? □Driver □Passenger □Front Seat □Back Seat □Using Seat Belts □Other Protective Devices
Did you feel pain immediately after the accident? □ Yes □ No □ Later that day □ Next day □ Other
If other, when? _____
Where did you feel pain immediately after the accident? _____
Where were you taken after the accident? _____
Was treatment given? □ Yes □ No Was any Doctor consulted after the accident? □ Yes □ No
If so, give Doctor's name: _____ □ D.C. □ M.D. □ D.O. □ D.D.S
Doctor's Diagnosos: _____
What Treatment was given? _____
How often did you see the Doctor? _____
How long did you see the Doctor? _____
Before the injury, were you capable of working on an equal basis with others your age? □ Yes □ No
Are your work activities restricted as a result of this accident? □ Yes □ No
Since the injury, are your symptoms: □ Improving? □ Getting Worse? □ Staying the Same?

Health Questionnaire

Please indicate your current health issues:

	MUSCULO-SKELETAL SYSTEM		GENITO-URINARY SYSTEM		GASTROINTESTINAL SYSTEM		CARDIO-VASCULAR RESPIRATORY
	Low back pain		Bladder trouble		Poor appetite		Chest Pain
	Shoulder blade pain		Excessive urination		Excessive hunger		Pain over heart
	Neck pain		Scanty urination		Difficult chewing		Difficult breathing
	Arm pain		Painful urination		Difficult swallowing		Persistent cough
	Leg pain		Discolored Urine		Excessive thirst		Coughing blood
	Swollen joints				Nausea		Coughing phlegm
	Painful joints				Vomiting food		Rapid heartbeat
	Stiff joints				Vomiting blood		Blood pressure issues
	Sore muscles				Abdominal pain		Heart problems
	Weak muscles				Diarrhea		Lung problems
			FEMALE		Constipation		Varicose veins
			Vaginal bleeding		Black stool		
			Vaginal discharge		Hemorrhoids		
			Vaginal pain		Liver trouble		
			Breast pain		Gall bladder pain		
			Lumps in breast		Weight trouble		

	NERVOUS SYSTEM		EYE,EAR,NOSE&THROAT
	Numbness		Eye strain
	Loss of feeling		Eye inflammation
	Paralysis		Vision problems
	Dizziness		Ear pain
	Fainting		Ear noises
	Headaches		Ear discharge
	Muscle jerking		Hearing loss
	Convulsions		Nose pain
	Forgetfulness		Nose bleeding
	Confusion		Nose discharge
	Depression		Difficult breathing thru nose
			Sore gums
			Dental problems
			Sore mouth
			Sore throat
			Hoarseness
			Difficult speech



Please mark your areas of pain on the figures above.

FEMALE ONLY: My signature indicates that, "This is to certify, to the best of my knowledge that I am not pregnant at this time. I hereby authorize the chiropractic clinic/doctors to take X-rays as necessary to determine the status of my spine. I will assume all responsibility for any effects on a fetus potentially present."

Printed Name_____Signature_____Date_____

I hereby authorize this office and its doctors to administer care to myself or my child as they deem necessary.

_____ _____

Signature of Patient (or parent if a minor) Date