Sjogren Chiropractic Center Inc.

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Name _____ Date of Birth _____ Phone _____
Address _____ City _____ State _____ Zip _____
Employer's Name _____ Employer's Address _____
Your Ins. Co. _____ _____ Policy # _____ Agent's Name _____
Driver/Other Vehicle _____ _____ Ins. Co. _____ Policy # _____
Have you retained an attorney?( ) Yes ( ) No Name _____
Were there any witnesses? ( ) Yes ( ) No Name(s)_____

Nature of Accident:

1. Date of Accident: _____ Time of Day _____
2. Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat
3. Number of people in your vehicle? _____ Other Vehicle? _____
4. What direction were you headed? ( ) North ( ) East ( ) South ( ) West
   on (name of street) _____
5. What direction was the other vehicle headed? ( ) North ( ) East ( ) South ( ) West
   on (name of street) _____
6. Were you struck from: ( ) Behind ( ) Front ( ) Left side ( ) Right side
7. Were you knocked unconscious? ( ) Yes ( ) No. If yes, for how long? _____
8. Were police notified? ( ) Yes ( ) No
9. In your own words, please describe accident: _____

   _____

   _____
10. Did you have any physical complaints BEFORE THE ACCIDENT?( )Yes ( ) No
    If yes, please describe in detail: _____

    _____
11. What are your PRESENT complaints and symptoms? _____

    _____
12. Where were you taken after the accident? _____
13. Have you ever been treated by another doctor since the accident? ( ) Yes ( ) No.
    If yes, please list doctor's name and address: _____

    What type of treatment did you receive? _____

    _____
14. Since this injury occurred, are your symptoms: ( ) Improving ( ) Getting Worse ( ) Same
19. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

☐ Headache	☐ Irritability	☐ Numbness in Toes	☐ Face Flushed	☐ Feet Cold
☐ Neck Pain	☐ Chest Pain	☐ Shortness of Breath	☐ Buzzing in Ears	☐ Hands Cold
☐ Neck Stiff	☐ Dizziness	☐ Fatigue	☐ Loss of Balance	☐ Stomach Upset
☐ Sleeping Problems	☐ Head seems Too Heavy	☐ Depression	☐ Fainting	☐ Constipation
☐ Back Pain	☐ Pins & Needles in Arms	☐ Lights Bother Eyes	☐ Loss of Smell	☐ Cold Sweats
☐ Nervousness	☐ Pins & Needles in Legs	☐ Loss of Memory	☐ Loss of Taste	☐ Fever
☐ Tension	☐ Numbness in Fingers	☐ Ears Ring	☐ Diarrhea	

Symptoms Other Than Above _____

20. Have you lost time from work as a result of this accident? ( ) Yes ( ) No.
    a. Last Day Worked:_____ Type of Employment?_____
21. Do you notice any activity restrictions as a result of this injury?( ) Yes ( ) No.
    If yes, please describe, in detail:

_____ _____
Signature Date: