

Petersen Chiropractic
PO Box 370 Belfair, WA 98528
Phone: 360-275-8727 Fax: 360-275-9695

PATIENT HISTORY

Name: _____
Address: _____

Phone: _____
Social Security #: _____
Birth Date: _____

Employer: _____
Address: _____

Phone: _____
Driver License #: _____

Insurance Information

YOUR...
Insurance Co.: _____
Policy # _____
Agents Name: _____
Claim #: _____
Adjuster: _____

Other Vehicle:
Drivers Name: _____
Insurance Co: _____
Name of Policy Holder: _____
Policy #: _____
Claim #: _____

Were there any witnesses? Yes () No ()
Names: _____

Have you retained an attorney? Yes () No ()
Name: _____
Contact Phone: _____

Accident Information

1 Date of accident: _____ Time of Day: _____

2 Location: _____
(Street Name, City)

3 Were you the: Driver () Passenger () Front Seat () Back Seat ()

4 Number of people in your vehicle: _____ Other vehicle: _____

5 Describe the accident in detail: _____

6 Pavement: Wet () Dry () Foot on brake? Yes () No ()

7 A. Your vehicle make/model: _____
B. Other vehicle make/model: _____

8 Headrest up? Yes () No ()

9 Were you aware the accident was about to occur? Yes () No ()

10 Was your seatbelt on? Yes () No () Which one? Lap () Shoulder () Both ()

11 Position of head: Straight () To Right () To Left ()

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12 Did any of your body contact anywhere in your vehicle? (ie. Dash, window, door) Yes () No ()

Describe: _____

13 Did you sustain any cuts, abrasions or fractures? Yes () No () Describe: _____

14 Did you lose consciousness? Yes () No ()

15 Were you hospitalized? Yes () No ()

16 Are you taking any medications? Yes () No () Please list: _____

17 Have you had any other care related to this accident? Yes () No () Explain: _____

18 Was a police report made? Yes () No ()

19 Was the driver of your car cited? Yes () No () Other Driver? Yes () No ()

20 Did you have any physical complaints prior to this accident? Yes () No () Explain: _____

21 Check symptoms you have noticed since the accident:

- | | | |
|-----------------------|------------------------------|-------------------------|
| () Headache | () Irritability | () Numbness in Toes |
| () Neck Pain | () Chest Pain | () Shortness of Breath |
| () Neck Stiff | () Dizziness | () Fatigue |
| () Sleeping Problems | () Head Seems too Heavy | () Depression |
| () Back Pain | () Pins and Needles in Arms | () Lights Bother Eyes |
| () Nervousness | () Pins and Needles in Legs | () Ears Ring |
| () Tension | () Numbness in Fingers | () Constipation |
| () Face Flushed | () Diarrhea | () Cold Sweats |
| () Buzzing in Ears | () Feet Cold | () Fever |
| () Loss of Balance | () Hands Cold | () Loss of Smell |
| () Fainting | () Stomach Upset | |
| () Loss of Taste | () Other _____ | |

22 Have you lost time from work as a result of this accident? Yes () No () If yes.....

A Last Day Worked: _____

B Type of Employment: _____

C Are you being compensated for time lost from work? Yes () No () If yes, what type of compensation are you receiving? _____

23 Do you notice any activity restrictions as a result of this injury? Yes () No () Explain: _____

Signature: _____ Date: _____