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 Employement: _____

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: _____