



General Information- Auto Collision

Name _____ Birth Date ___/___/___ Today's Date ___/___/___
Address _____ City/State/Zip _____
Age _____ Home # _____ Work # _____ Cell # _____
Best phone: Home ___ Work ___ Cell ___ Email: _____
Occupation _____ Employer _____
Relationship Status: *Single* *Married* *Partner* Children: *Yes* *No*
How did you find us? Who can we thank for referring you? _____
Social Security # _____ Emergency Contact _____ Phone _____

Insurance Information

Auto Insurance Info:

Insurance Company _____ Claim # _____ Policy # _____
Adjuster's Name _____ Phone _____

Your Auto Insurance Info (if you were not at fault):

Insurance Company _____ Claim # _____ Policy # _____
Agent's Name _____ Phone _____

Are you using an Attorney? If yes, Name _____ Phone _____

Your Personal Health Insurance: If using another family member's policy, please list their:

Name _____ Date of Birth _____

****Please present your insurance card for us to copy****

Injury Information

Date of Accident _____ Time _____

Driver of Car _____ Who owns the car? _____

Year and model of your car _____ Other car _____

Where were you seated? _____ Approximate damage to your car \$ _____

Visibility at the time of the accident: Poor Fair Good Comments: _____

Road conditions at the time of the accident: Icy Rainy Wet Clear Dark other

Type of Accident: Head on collision Broad-side collision Rear-end collision Front Impact

At the time of the accident, recall what parts of your head or body hit what parts on the inside of the car:

Did you see the accident coming? Yes No

Did you brace for impact Yes No

Were seatbelts worn? Yes No

Does your car have headrests? Yes No

If yes, what was the position of those headrests before the accident?

Top of headrest even with bottom of head Top of headrest even with top of head Top of headrest even with neck

Was your car breaking? Yes No Was your car moving at the time of the accident? Yes No

If moving, how fast would you estimate you were going? _____ MPH The other car? _____ MPH

Head body position at the time of impact:

Head turned to the Left Right Head looking back Head straight forward

Body straight in sitting position Body rotated Left Right Other

Injury Information

What changes have you noticed since the collision?

Please mark all symptoms you have noticed since the accident:

<input type="checkbox"/> Headache	<input type="checkbox"/> Neck pain/stiffness	<input type="checkbox"/> Mid back pain	<input type="checkbox"/> Eye light sensitivity
<input type="checkbox"/> Pain behind the eyes	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Fainting	<input type="checkbox"/> Sleeping problems
<input type="checkbox"/> Numbness in the toes	<input type="checkbox"/> Loss of smell	<input type="checkbox"/> Loss of taste	<input type="checkbox"/> Numbness in fingers
<input type="checkbox"/> Loss of memory	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Breath shortness	<input type="checkbox"/> Irritability
<input type="checkbox"/> Depression	<input type="checkbox"/> Ringing/Buzzing	<input type="checkbox"/> Loss of balance	<input type="checkbox"/> Tension
<input type="checkbox"/> Cold Hands	<input type="checkbox"/> Cold Feet	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Constipation
<input type="checkbox"/> Chest Pains	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Cold sweats	<input type="checkbox"/> Anxious
<input type="checkbox"/> Facial Pain	<input type="checkbox"/> Clicking or popping jaw	<input type="checkbox"/> Low back pain	<input type="checkbox"/> Muscle soreness
<input type="checkbox"/> Other: _____			

Have you missed time from work? Y N If yes from _____ to _____

Did you seek medical help immediately after the accident? Y N

If yes, how did you get there? Ambulance Police someone else drove Drove own car

Doctor #1 Name: _____ First visit date: _____

Were you examined? Yes No Were x-rays taken? Y N

What treatment did you receive, did it help? _____

Doctor #2 Name (if any): _____ First visit date: _____

Were you examined? Yes No Were x-rays taken? Y N

What treatment did you receive, did it help? _____

Explanation of Care

-Thrive Chiropractic Center exists to make a positive contribution in the lives of people, by assisting them to express and experience more health and vitality in their bodies and in their lives.

-Chiropractic is a science and healing art focused on the relationship between structure, primarily of the spine, and function, primarily of the nervous system.

-The nerve system is used for the transfer of vital information essential for all human works—from bodily functions to emotions, creativity, performance, perception and expression. The nerve system is our link between the inner and outer world and consists of the brain, spinal cord, nerves, and neurotransmitters. All cells of the body are regulated through the nerve system.

-The function of the nervous system affects the health of the body. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

-A misalignment of structures in the spine can cause changes in nerve function and interference in the communication system within the body. This condition results in a lessening of the body's innate ability to express its maximum health potential.

-The chiropractic adjustment is a specific application of forces, by hand or instrument, to correct misalignments. The adjustment can help restore and enhance the full function and communication within your body, from the brain to every organ, tissue and cell.

-I understand my right to be informed about the condition of my health and the care options available and that it is my choice to accept or decline chiropractic care. I understand that I am responsible for payment at the time services are rendered unless other arrangements are agreed upon.

RELEASE AND ASSIGNMENT: I authorize release of any information necessary to process my insurance claims and assign and request payment directly to my physicians.

Should insurance fail to pay for services I receive, I authorize the following credit card to be used as payment:

Credit/Debit Card Number: _____

Name on Card: _____ Exp. Date: _____ Security Code: _____

Patient Signature _____ Date _____