

**M I R T S C H I N G D . C .**  
**D E W A Y N E M .**  
**DOCTOR OF CHIROPRACTIC**

**ACCIDENTAL INJURY REPORT**

If your clinic visit is due to an accident, please describe all events associated with it.

Date of Accident \_\_\_\_\_ Hour of Accident \_\_\_\_\_  AM  PM  
 Type of Accident  Work Related  Traffic  Other

**Work Related Accident**

Employer Name \_\_\_\_\_ Type of Business \_\_\_\_\_  
 Was any Equipment, Machinery and/or Object related to Accident? What Kind? \_\_\_\_\_  
 Was accident reported to Supervisor and/or Employer?  YES  NO  
 Has a Workers' Compensation Claim been filed?  YES  NO

**Traffic Accident**

What kind of vehicle was involved in accident?  TRUCK  CAR  MOTORCYCLE  OTHER  
 Were you a  DRIVER  PASSENGER  PEDESTRIAN  
 If a Passenger, please indicate your location in the car.  
 Was your vehicle moving when the accident occurred?  YES  NO MPH? \_\_\_\_\_  
 Did your vehicle hit other vehicle/s?  YES  NO Where? \_\_\_\_\_  
 Did other vehicle/s hit your vehicle?  YES  NO Where? \_\_\_\_\_  
 Was accident reported to Police Department?  YES  NO  
 Were traffic citations issued?  YES  NO To Whom? \_\_\_\_\_  
 Describe accident including causes & surrounding circumstances:

**Present Complaint**

<input type="checkbox"/> Headache	<input type="checkbox"/> Pins & Needles in Arms/Legs	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Head Seems Too Heavy	<input type="checkbox"/> Numbness in Fingers, Arms, Legs	<input type="checkbox"/> Extreme Fatigue
<input type="checkbox"/> Head & Shoulders Tired & Heavy	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Insomnia
<input type="checkbox"/> Mental Dullness	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Neuritis
<input type="checkbox"/> Loss of Memory	<input type="checkbox"/> Eye Strain	<input type="checkbox"/> Face Flushed
<input type="checkbox"/> Equilibrium Problems	<input type="checkbox"/> Pain Behind Eyes	<input type="checkbox"/> Face Pale
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Eyes Sensitive to Light	<input type="checkbox"/> Excess Perspiration
<input type="checkbox"/> Fainting	<input type="checkbox"/> Eyes Loss of Focus	<input type="checkbox"/> Digestive Disorders
<input type="checkbox"/> Tremors	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Nausea, Vomiting
<input type="checkbox"/> Palpitation	<input type="checkbox"/> Ears Buzzing/Ringing	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Loss of Taste	<input type="checkbox"/> Constipation
<input type="checkbox"/> Neck Stiffness	<input type="checkbox"/> Loss of Smell	<input type="checkbox"/> Depression
<input type="checkbox"/> Neck Motion Restricted	<input type="checkbox"/> Sinus Trouble	<input type="checkbox"/> Swollen
<input type="checkbox"/> Upper Back Pain/Stiffness	<input type="checkbox"/> Extreme Nervousness	<input type="checkbox"/> Feet/Hands Cold
<input type="checkbox"/> Mid Back Pain/Stiffness	<input type="checkbox"/> Tension	<input type="checkbox"/> Irritability
<input type="checkbox"/> Low Back Pain/Stiffness	<input type="checkbox"/> Difficulty in Prolonged Car Ride	

Difficulty in Excessive  Standing  Walking  Riding  Bending  
 Neck, Low Back Pain & Stiffness Upon Rising  
 Pain Radiating Into  Right Arm  Right Leg  Both  Left Arm  Left Leg  Both  
 Difficulty in Excessive Lifting  Light  Moderate  Heavy  Repetitive  
 Pain Radiating Into  Neck  Base of Skull  Shoulder  Arms  Hips  Legs

Did you require post-accident hospitalization?  YES  NO If so, where? \_\_\_\_\_  
 Have you had similar accidents or injuries before?  YES  NO  
 Symptoms other than above listed \_\_\_\_\_

**Insurance Companies Involved**

Insurance Company of party responsible for payment \_\_\_\_\_ Claim # \_\_\_\_\_  
 Have you been contacted by an Insurance Adjuster or Company Representative about Claim?  YES  NO  
 Has your Attorney advised you in this case?  YES  NO  
 Attorney's Name \_\_\_\_\_ Telephone \_\_\_\_\_  
 Address \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient Name \_\_\_\_\_