



ARCADIA CHIROPRACTIC CLINIC, INC.

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IF YOURS IS AN ACCIDENT INJURY, PLEASE COMPLETE THE FOLLOWING:

Date of Accident: _____ Hour: ____AM ____PM

Location: _____

How did the accident occur? Auto Collision On-the-job injury Other _____

If work-related, did you report the injury to your foreman or employer?: Yes No

If work-related did he (they) recommend care at our office? Yes No

If auto accident, were you the Driver Passenger Pedestrian

If auto accident, were you struck from Behind Right side Left side Front

Did your car strike the other(s) involved Yes No

If not, did the other car strike you? Yes No

As a result of the accident, were traffic citations issued to you? Yes No

Were traffic citations issued to the driver of the other car? Yes No

Did you require post-accident hospitalization? Yes No

Did you receive x-ray or other diagnostic studies? Yes No

If yes, where was this performed? _____

Please check all symptoms you have noticed since the accident:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Irritability | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Hands/feet cold |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Buzzing ears |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Stomach Upset | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Head seems too heavy | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Fainting spells |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Pins & Needles in arms | <input type="checkbox"/> Lights bothers eyes | <input type="checkbox"/> Loss of smell |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Loss of taste |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Ringing ears | <input type="checkbox"/> Diarrhea |

Symptoms other than above: _____

As a result of this accident, have you lost any days of work: Yes No

Please list dates missed: _____

Have you been contacted by an Insurance Adjustor or company representative regarding this claim?

Yes No Name: _____

Attorney representing you in this case: _____

PLEASE PROVIDE THE FRONT OFFICE WITH A COPY OF YOUR ACCIDENT REPORT