GREEN HILLS CHIROPRACTIC CLINIC
Your Chiropractic Family

2000 Glen Echo Rd, Suite 120
Nashville, TN 37215
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AUTO ACCIDENT FORM

PATIENT INFORMATION

Today's Date: _____ **Date of Collision:** _____

First Name: _____ **Last Name:** _____

Phone: _____ ☐ mobile ☐ home ☐ work

Address: _____

City: _____ **State:** _____ **Zip:** _____

Email: _____

DOB: _____ **Sex:** ☐ male ☐ female

Marital Status: ☐ single ☐ married ☐ other

Working Status: ☐ employed ☐ full-time student ☐ part-time student

Employer Name: _____

Employer Phone: _____ **Occupation:** _____

AUTO INSURANCE

PRIMARY INSURANCE:

Insurance Name: _____

Insurance Phone: _____ **ID#:** _____ **Group #:** _____

Name of Insured: _____

DOB: _____ **SSN:** _____

Copay _____ **Deductible** _____ **Co-Ins** _____

Relationship to insured: ☐ self ☐ spouse ☐ child ☐ other: _____

SECONDARY INSURANCE:

Insurance Name: _____

Insurance Phone: _____ **ID#:** _____ **Group#:** _____

Name of Insured: _____

DOB: _____ **SSN:** _____

Copay _____ **Deductible** _____ **Co-Ins** _____

Relationship to insured: ☐ self ☐ spouse ☐ child ☐ other: _____

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AUTO ACCIDENT FORM

ACCIDENT HISTORY

When did the accident occur?

____ days ago ____ weeks ago ____ years ago other: _____

Where were you located at the time of the accident?

☐ driver ☐ front passenger ☐ rear passenger ☐ pedestrian

If you were not the driver, please provide the name, address, and telephone number of the driver:

_____

_____

How many passengers were in the accident vehicle? _____

Have you retained an attorney? ☐ yes ☐ no

ATTORNEY INFORMATION:

Attorney Name: _____

Address: _____ **Phone:** _____

DRIVER OF OTHER VEHICLE INFORMATION:

Other Driver Name: _____

Address: _____ **Phone:** _____

ACCIDENT INFORMATION

Where did the accident occur?

☐ intersection ☐ parking lot ☐ in town ☐ on the interstate

☐ highway other: _____

What is the make and model of your vehicle? _____

How many vehicles were involved in the accident? _____

At impact, your vehicle was: ☐ stopped ☐ slowing down ☐ speeding up

At impact, the other vehicle was: ☐ stopped ☐ slowing down ☐ speeding up

What time of day did the accident occur? ☐ morning ☐ afternoon ☐ evening ☐ night

Driving conditions at time of accident: ☐ normal ☐ dry ☐ icy ☐ stormy ☐ wet ☐ windy

Type of impact: ☐ side-driver's ☐ side-passenger's ☐ front ☐ rear

Did the vehicle hit another structure after the accident? ☐ no ☐ building ☐ ditch

☐ fire hydrant ☐ median ☐ second vehicle ☐ railing ☐ pole ☐ tree

☐ other: _____

Was your vehicle struck by another vehicle? ☐ yes ☐ no

Did any part of your body strike anything in the vehicle?

☐ face ☐ jaw ☐ neck ☐ shoulders ☐ chest ☐ hips

☐ legs ☐ shins ☐ knees ☐ feet ☐ other: _____

ACCIDENT INFORMATION (continued)

At impact, you were looking: ☐ straight ahead ☐ left ☐ right ☐ up ☐ down

Which hands were on the steering wheel? ☐ none ☐ both ☐ left ☐ right

Which foot was on the break? ☐ both ☐ neither ☐ left ☐ right

What air bags deployed? ☐ none ☐ steering wheel ☐ driver's side ☐ passenger's side

Were you wearing a seatbelt? ☐ yes ☐ no

What doors would not open as a result of the accident?

☐ all doors freely opened ☐ front left ☐ front right ☐ rear left ☐ rear right

☐ other: _____

Did you go to the hospital? ☐ yes ☐ no

HOSPITAL INFORMATION

Hospital Name: _____ **Location:** _____

Were you hospitalized overnight? ☐ yes ☐ no

Were you prescribed anything?

☐ arm brace ☐ crutches ☐ knee brace ☐ leg brace

☐ muscle relaxers ☐ neck brace ☐ pain medication ☐ topical analgesic

☐ wrist brace ☐ other: _____

Services performed:

☐ none ☐ evaluation by a medical doctor ☐ x-rays ☐ MRI ☐ CT scan

☐ cast ☐ emergency life saving procedures ☐ blood transfusion ☐ stitches

☐ other: _____

Diagnostic tests performed:

☐ amniocentesis ☐ basal metabolic panel ☐ biopsy ☐ celiac profile

☐ complete blood count ☐ complete blood count with differential ☐ CAT scan

☐ colonoscopy ☐ comprehensive metabolic panel ☐ diagnostic ultrasound ☐ echocardiogram

☐ electrolyte panel ☐ endoscopy ☐ extended cardiac risk profile ☐ hepatic function panel

☐ hepatitis panel, acute ☐ hepatitis panel, chronic ☐ lipid panel ☐ mammogram

☐ MRI ☐ OB profile ☐ PET scan ☐ renal panel ☐ urinalysis ☐ x-ray/x-ray series

CONDITION

What treatments have you received since the accident?

☐ ice ☐ heat ☐ oral pain medication ☐ topical analgesics ☐ muscle relaxers

☐ crutches ☐ wrist brace ☐ knee brace ☐ ankle brace ☐ other: _____

How often have you been receiving treatment?

☐ daily ☐ twice per week ☐ 3 times/week ☐ 4 times/week ☐ 5 times/week

☐ weekly ☐ bi-weekly ☐ monthly

CONDITION (continued)

Details of treatment received: _____

Location and provider where previous treatment was received:

_____

_____

Are you responding to treatment? ☐ same ☐ improving ☐ worse ☐ other: _____

How did you feel immediately following the accident?

☐ head pain ☐ neck pain ☐ neck stiffness ☐ jaw/facial pain (TMJ) ☐ shoulder pain
☐ back pain ☐ arm pain ☐ chest pain ☐ shoulder stiffness ☐ low back pain
☐ lower limb pain ☐ back stiffness ☐ cold feet ☐ cold hands ☐ cold sweats
☐ ear buzzing/ringing in the ears ☐ feet/toe numbness or tingling ☐ constipation ☐ anxiety
☐ hands/fingers numbness or tingling ☐ upper lip numbness or tingling ☐ depression
☐ diarrhea ☐ difficulty swallowing ☐ dizzy/dazed ☐ disoriented ☐ fainting
☐ fatigue ☐ forgetfulness ☐ impaired concentration ☐ sensitivity to light ☐ irritability
☐ sensitivity to noise ☐ loss of balance ☐ loss of smell ☐ loss of taste ☐ weakness
☐ loss of memory ☐ muscle spasms ☐ nauseous ☐ pins and needles ☐ nervousness
☐ restlessness ☐ vision blurred ☐ sleeping problems ☐ stomach upset
☐ tension ☐ shortness of breath

What symptoms did you experience since the accident?

☐ head pain ☐ neck pain ☐ neck stiffness ☐ jaw/facial pain (TMJ) ☐ shoulder pain
☐ back pain ☐ arm pain ☐ chest pain ☐ shoulder stiffness ☐ low back pain
☐ lower limb pain ☐ back stiffness ☐ cold feet ☐ cold hands ☐ cold sweats
☐ ear buzzing/ringing in the ears ☐ feet/toe numbness or tingling ☐ constipation ☐ anxiety
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☐ sensitivity to noise ☐ loss of balance ☐ loss of smell ☐ loss of taste ☐ weakness
☐ loss of memory ☐ muscle spasms ☐ nauseous ☐ pins and needles ☐ nervousness
☐ restlessness ☐ vision blurred ☐ sleeping problems ☐ stomach upset
☐ tension ☐ shortness of breath

Describe the pain: ☐ aching ☐ burning ☐ cramping ☐ deep ☐ dull ☐ numb
☐ radiating ☐ sharp ☐ shooting ☐ stabbing ☐ stiff ☐ swelling ☐ tight
☐ tingling ☐ throbbing

Rate your pain on a scale of 0 to 10 *(0 being no pain at all and 10 being the worst pain imaginable)* _____

How many days of work have you missed as a result of this accident? _____

Have you receive x-rays for this accident? ☐ yes ☐ no

If yes, by whom? _____

GREEN HILLS
Chiropractic Clinic

AUTO ACCIDENT FORM

EMERGENCY CONTACT

Name: _____

Phone: _____ **Relationship:** _____

HEALTH HISTORY

MEDICATION	DOSAGE/FREQUENCY	REASON FOR TAKING

Do you have any allergies? ☐ yes ☐ no

If yes, please list them below:

_____

_____

History of trauma/surgery? ☐ yes ☐ no

If yes, please provide details below:

_____

_____

Do you or have you ever suffered from other health disorders or major illness?

☐ diabetes ☐ heart/lung disease ☐ cancer ☐ stroke ☐ thyroid problems
☐ arthritis ☐ osteoporosis ☐ other: _____

Is there a history of any of the above or other health disorders in your family? ☐ yes ☐ no

If yes, please provide details: _____

PAYMENT POLICY

The above named Chiropractic clinic may use my healthcare information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I understand, regardless of my insurance status, I am ultimately responsible for any charges for professional services rendered by the above named Chiropractic clinic.

_____ Date: _____

Signature of Patient, Parent, Guardian or Personal Representative

_____ Date: _____

Print Name of Patient, Parent, Guardian or Personal Representative