WALKER ROAD CHIROPRACTIC
Chiropractic, Rehab & Massage

Personal Injury Form

Patient's Name: _____ Today's Date: _____

Accident Details

-**Date of accident**: ____/____/____ -**Time of accident**: ____ : ____ am / pm

-**Type of accident?** □ Workers compensation accident / injury □ Slip / Fall □ Pedestrian accident
□ Other type of accident / injury (*please explain*)_____

-**Describe in your own words what happened**:_____

_____

_____

_____

_____

-Loss of consciousness? □ Yes □ No □ Unknown **-Were you stunned?** □ Yes □ No (*for how long*? _____)

- **Did you feel or hear popping, tearing, or ripping noises in your neck or back?** □ Yes □ No
if "yes", please explain:_____

Did you feel any pain? □ Yes □ No *if "yes" where?*_____
How long after the accident? _____

Did you find any bruises or lacerations (cuts)? □ Yes □ No (*where?*) _____

List the extent of your injuries as you know them: _____

_____

_____

_____

_____

Please check any symptoms that you have experienced since the accident.

□Headache
□Skull or head pain
□Neck pain
□Neck stiffness
□Head feels too heavy
□Shoulder pain
□Shoulder stiffness
□Arm pain
□Arm Numbness
□Pins and needles in arms
□Numbness in hands/fingers
□Cold hands
□Upper back pain
□Upper back stiffness
□Mid back pain
□Mid back stiffness
□Chest pain
□Rib pain
□Painful breathing
□Other symptoms: _____
□Other symptoms: _____

□Low back pain
□Low back stiffness
□Hip pain
□Buttock pain
□Leg pain
□Leg numbness
□Pins and needles in legs
□Numbness in feet/toes
□Cold feet
□Depression
□Anxiety
□Tension
□Irritability
□Nervousness
□Mental dullness
□Loss of memory
□Difficulty sleeping
□Fatigue
□Tremors

□Face flushed
□Loss of color
□Dizziness
□Fainting
□Sinus trouble
□Loss of smell
□Eye stain
□Difficulty focusing
□Pain behind eyes
□Eyes sensitive to light
□Double Vision
□Buzzing or ringing in ears
□Loss of balance
□Palpitations
□Shortness of breath
□Digestive problems
□Nausea
□Vomiting
□Diarrhea
□Other symptoms: _____
□Other symptoms: _____

□Constipation
□Excessive perspiration
□Loss of perspiration
□Loss of taste
□Cold sweats
□Fever
□Swelling, where: _____
□Difficulty in:
□Riding in car
□Bending
□Standing
□Sitting
□walking
□lifting
□Twist/Turning
□Difficulty rising to walk
□Pain doing occupation

WALKER ROAD CHIROPRACTIC

-Did you require post-accident care or hospitalization? □ Yes □ No (*where?)*_____

How soon after the accident? □ Immediately / Same day □ Next day □ Other:_____

-Were you examined? □ Yes □ No (*by whom*?)_____

Was a diagnosis given?_____

-Have you had any of the following tests (*pertaining to this injury only*)?

□X-rays □CT scan □MRI □Constipation □Other:_____

-Did you seek any medical care elsewhere? □ Yes □ No

□General Practitioner
-Name_____
-Diagnosis/plan_____

□Internist
-Name_____
-Diagnosis/plan_____

□Chiropractor
-Name_____
- Diagnosis/plan_____

□Neurologist
-Name_____
- Diagnosis/plan_____

□Orthopedist
-Name_____
-Diagnosis/plan_____

□General Surgeon
-Name_____
-Diagnosis/plan_____

□Plastic Surgeon
-Name_____
- Diagnosis/plan_____

□Psychologist
-Name_____
- Diagnosis/plan_____

□Other:_____
-Name_____
- Diagnosis/plan_____

□Other:_____
-Name_____
- Diagnosis/plan_____

-Have you done any self-treatment for you symptoms?

□Ice □Heat □Bed rest □Over the counter medications □Other:_____

-What is your occupation? _____

-What are your job duties? _____

Have you missed work as a result of this accident? □ Yes □ No (*how many days?)* _____

(from / /20 to / /20)

Additional Comments: _____

Patient Signature (Guardian's if a minor): _____

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