DEMETREE CHIROPRACTIC GROUP

MATTHEW C. DEMETREE, D.C.
DEMETREE CHIROPRACTIC GROUP
3505 S. ORLANDO DRIVE
SANFORD, FL 32773
(407) 324-8222

Auto Accident Information

NAME:_____ **DATE**:_____**Phone:**_____

E-Mail_____ **Cell:** _____

Birthdate: _____ Male/Female Social Security # _____

Address: _____City: _____State:_____Zip:_____

Referred by: _____

Spouse:_____

INSURANCE INFORMATION:

Your Auto Insurance Company _____

Policy# _____ Claim # _____

Policy Holder's Name: _____

Attorney Name: _____Firm:_____Phone#_____

Your Health Insurance Company:_____

Policy Holder's Name:_____ SS# _____ Birthdate _____

Policy # _____ Group # _____

NATURE OF ACCIDENT:
Date of Accident:_____Time of Day_____( )AM ( )PM

Were there any witnesses? ( ) Yes ( ) No
Names_____

1. Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat
2. Number of people in your vehicle? _____ Were you wearing seat belts?_____
3. What direction were you headed? ( ) North ( ) East ( ) South ( ) West
   On (name of street)_____
4. What direction was the other vehicle headed? ( ) North ( ) East ( ) South ( ) West
   On (name of street)_____
5. Were you struck from: ( ) Behind ( ) Front ( ) Left side ( ) Right side
6. Approximate speed of your car_____mph Other car_____mph
7. Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long?_____

Patient Name _____ **Date** _____

8. Were police notified? ( )Yes ( )No

9. Was the impact a:
   ( )Head on Collision ( )Left Side Impact ( )Right Side Impact ( )Rear End Collision

10. To the best of you recollection, please describe the accident:_____
    _____
    _____

11. Did you have any physical complaints BEFORE THE ACCIDENT? ( )No ( )Yes, please describe in detail:_____

12. Please describe how you felt:
    a. DURING the accident:_____
    b. IMMEDIATELY AFTER the accident:_____
    c. LATER THAT DAY:_____
    d. THE NEXT DAY:_____

13. If vehicle had headrests, describe the headrest height compared to your head: was the top of the headrest aligned with the: ( )Top ( )Middle ( )Bottom …of your head?

14. List any parts of your body that made contact with vehicle parts._____
    _____

15. Were you braced for impact? ( )Yes ( )No

16. Were brakes applied? ( )Yes ( )No

17. Were you looking at outside door mirror? ( )L ( )R

18. Was your car stopped? ( )Yes ( )No

19. Were you looking up into inside rear view mirror? ( )Yes ( )No

20. What are your PRESENT complaints and symptoms?_____
    _____
    _____

21. Where were you taken after the accident?_____

22. Have you been treated by another doctor since the accident? ( )No ( )Yes, please list doctor's name and address:_____

23. What type of treatment did you receive?_____

24. Since this injury occurred, are your symptoms: ( )Improving ( )Getting Worse ( )Same

Patient Name _____ **Date** _____

25. CHECK ALL SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

( )Headache	( )Irritability	( )Numbness in Toes	( )Face Flushed	( )Feet Cold
( )Neck Pain	( )Chest Pain	( )Shortness of Breath	( )Buzzing in Ears	( )Hands Cold
( )Neck Stiff	( )Dizziness	( )Fatigue	( )Loss of Balance	( )Stomach
( )Sleep Problems	( )Head Seems Heavy	( )Depression	( )Fainting	( )Upset
( )Back Pain	( )Pins & Needles in Arms	( )Lights Bother Eyes	( )Loss of Smell	( )Constipation
( )Nervousness	( )Pins & Needles in Legs	( )Loss of Memory	( )Loss of Taste	( ) Cold Sweats
( )Tension	( )Numbness in Fingers	( )Ears Ringing	( )Diarrhea	( )Fever

Symptoms Other Than Above:_____

26. Have you lost time from work as a result of this accident? ( )No ( )Yes, please complete A-D.
    a. Last Day Worked:_____
    b. Type of Employment:_____
    c. Present Salary:_____
    d. Are you being compensated for time lost from work? ( )No ( )Yes, please state type of compensation you are receiving:_____

27. Do you notice any activity restrictions as a result of this injury? ( )No ( )Yes, please describe, in detail:_____

28. Do you have any congenital (from birth) factors, relating to this problem? ( )No ( )Yes, please describe_____
    _____

29. Do you have any previous illnesses, which relate to this case? (No ( )Yes, please describe:_____
    _____

30. Have you ever been involved in an accident before? ( )No ( )Yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received:_____
    _____
    _____

31. Other Pertinent Information:_____
    _____

I attest that the information disclosed herein is true and accurate to the best of my recollection.

_____ _____

DATE **PATIENT'S SIGNATURE**

Thank you for filling out this form completely. The information you have provided will help us serve your healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask – we are always happy to help.