Fresh Start Chiropractic, LLC

1465 Northside Dr. NW STE 212
Atlanta, GA 30318

Patient Name:_____ Date: _____
Date of Accident: _____ Date of EXAMINATION: _____
Insurance Company (Auto, Homeowners etc) _____
Address:_____
Policy number:_____
Claim Number:_____ Name of Adjustor:_____

If you have retained an attorney please provide the following information:
Name:_____
Address:_____
Telephone number:_____

Please provide this office with a copy of the police report. These are usually available within a 2-3 days after the accident.

HISTORY: - Automobile Accident/P.I.

____ Driver ____ Passenger ____ Pedestrian ___Other:_____

Traveling Direction or Stopped facing: NORTH SOUTH EAST WEST
Estimated speed of patient's vehicle: _____ Estimated speed of other vehicle: _____
Damage to patient's vehicle: _____
Location of Accident: Street:_____ City:_____
State:_____

DESCRIPTION OF ACCIDENT

_____
_____

Did the vehicle have seatbelts? YES NO Were you braced for the impact? YES NO
Were you wearing seatbelt? YES NO Were the brakes applied? YES NO
List your seat position in the vehicle: _____
Was the position of your headrest: _____ Directly behind your head
_____ Below the mid point of the back of your head.
_____ Absent
At the time of impact, was the position of your head: STRAIGHT TURNED RT.
TURNED LT.

Did you strike any object inside the car? YES NO
Which body parts struck any objects at the time of impact:
_____Head _____Face _____Chest _____Neck _____Back _____Shoulder (Rt/Lt)
_____Arm (Lt/Rt) _____Knee (Rt/Lt) _____Leg (Rt/Lt) Other:_____

Which objects were struck:
_____

Were you rendered: _____ Unconscious _____ Cut or Bleeding _____ Neither
If applicable, indicate any pains or abnormal sensations experienced, immediately following the accident:

_____

Indicate any actions taken immediately following the accident:

_____

HOSPITALIZATION: ***(If no hospital visit, skip to next section)***

Indicate method of delivery to hospital:_____ Ambulance _____ Driven by family, friend, etc.
_____ Drove yourself ___ Other:_____
Hospital: _____
Were you seen in the emergency room? YES NO
Were you admitted to the hospital? YES NO (If yes, length of stay? _____)
Indicate which procedures were performed while at hospital (including emergency room):

_____

Who was the first physician you consulted after this accident? *(If this is first office, skip to PAST HISTORY)*

Name & office location:_____
Type of Doctor:_____
What procedures were conducted: _____ Examination _____ X-rays

If Physical Therapy was used, where did you receive therapy? _____
Have you seen other physicians since the above physician? YES NO
If yes, name & location of physician(s):_____
Are you still under the care of the physician(s)? YES NO

PAST HISTORY:

Has the patient been involved in any previous automobile accidents, of any kind?
YES NO
If yes, indicates dates & details:

_____

Have you ever been treated for any other past conditions that might relate to the injuries you have suffered in this recent accident? YES NO If yes, explain:

_____

Have you ever undergone any surgeries or experienced any conditions that you feel are pertinent to your current condition? YES NO If yes, explain:_____

_____

Did you enjoy good health prior to this accident? YES NO – explain:

_____

Patient Signature:_____ Date:_____