Gruber Chiropractic

Accidental Injury Form

Name: ______________________________ Home Phone: ______________________
Address: ______________________ City: ____________ State: ________ Zip: ________
Age: ______________ Birth Date: ____________ Occupation: ____________________
Employer: ______________________________ Office Phone: __________________
Nearest Relative: ______________________________ Phone: __________________
Referred By: ______________________________ Date of Accident:____________
Did you report the injury to your foreman or employer? ❑ Yes / ❑ No
Did he (they) recommend care at our office? ❑ Yes / ❑ No
If auto accident, were you Driver / Passenger / Pedestrian
If auto collision, were you struck from Behind / Right Side / Left Side / Front / Auto was parked
Did your car strike the other(s) involved? ❑ Yes / ❑ No
OR did the other car strike yours? ❑ Yes / ❑ No
As a result of the accident were traffic citations issued to you ❑ Yes / ❑ No
To the driver of the other car? ❑ Yes / ❑ No
List the extent of the injuries as you know them: ______________________________
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Circle Symptoms You Have Noticed Since Accident:

❑ Headache	❑ Dizziness	❑ Light bothers eyes	❑ Diarrhea
❑ Neck pain	❑ Head seems too heavy	❑ Loss of memory	❑ Feet cold
❑ Neck stiff	❑ Pins & needles in arms	❑ Ears ring	❑ Hands cold
❑ Sleeping problems	❑ Pins & needles in legs	❑ Face flushed	❑ Stomach upset
❑ Back pain	❑ Numbness in fingers	❑ Buzzing in ears	❑ Constipation
❑ Nervousness	❑ Numbness in toes	❑ Loss of balance	❑ Cold sweats
❑ Tension	❑ Shortness of breath	❑ Fainting	❑ Fever
❑ Irritability	❑ Fatigue	❑ Loss of smell	

Other Symptoms: ____
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Have you lost any days work? ❑ Yes / ❑ No Dates______________________________
Insurance Companies involved: My Company______________________________
Company of person responsible for my injuries______________________________
Has insurance company been contacted? ❑ Yes / ❑ No
Additional information about the accident you think we should know:____________________
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