New Patient Intake – Slip and Fall

Owens Chiropractic 33650 6th Ave S. Suite 100 Federal Way, Way 98003 (P) 253-942-3300

Patient Name: ____

Date of Accident: ______________________________________

Your Insurance

Claim # _______________________ Policy # ______________________

Insurance Company ____

Address ____

Adjuster _____________________Phone#____________________________

Responsible Insurance

Claim # _______________________ Policy # ______________________

Insurance Company ____

Address ____

Adjuster ______________________ Phone _______________________

Time of Accident: ________________ AM / PM

Location of Accident: ____

In as much detail as possible, please describe how your injuries occurred:____________________

____

____

____

____

Could you move all parts of your body after the accident? □ yes □ no

If no, what parts couldn't you move and why? ________________________

Were you able to walk unaided following the accident? □ yes □ no

If no, why? ____

Did you get any bruises? □ yes □ no If yes, where? _________________________________

Did you have any bleeding cuts? □ yes □ no If yes, where?_____________________________

Please describe how you felt:

Immediately after the accident: ___________________________________

Later that day: ____

The next day: ____

Check symptoms that have appeared since the accident:

__Foot/ Ankle Pn Lt / Rt	__Non Migraine Headaches	__Paresthesia LE
__Lower Leg Pn Lt/ Rt	__Migraines	__Paresthesia UP
__Knee Pn Lt/ Rt	__ Dizziness/ Vertigo	__Light Headed
__Thigh Pn Lt/ Rt	__Shoulder Pn Lt/ Rt	__Anxiety
__Hip Pn Lt/ Rt	__Upper Arm Lt/ Rt	__Depression
__Lumbar Pain	__Lower Arm Pn Lt/ Rt	__Irritability
__Thoracic Pain	__Wrist Pn Lt/ Rt	__Jaw Popping/ Clicking
__Neck Pain	__Hand Pn Lt/Rt	__Tinitus

Did you seek medical help immediately after the accident? □ yes □ no

If yes, how did you get there? □ someone else took me □ police □ ambulance

□ drove my own car □ other:

Doctor 's Name: ____

Practice Name & Address: ____

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Date of First Visit: ____

Where X-rays taken? □ yes □ no

Did you receive: □ collar □ brace (s) □ medication (s) □ other:____________________

If yes to medication (s), what did you receive? ____________________

____

What benefits did you receive from the treatment? ____________________________

____

Date of last treatment? ______________________________

Do you have an attorney for this claim? □ yes □ no

If yes, who? ____________________________________

Address: ____________________________________

City: ____________________ State: __________ Zip: ____________

Phone: ____________________________________

Patient's Signature ______________________________ Date ____________________

Printed Name ____