STARKWOOD CHIROPRACTIC

Auto Injury History

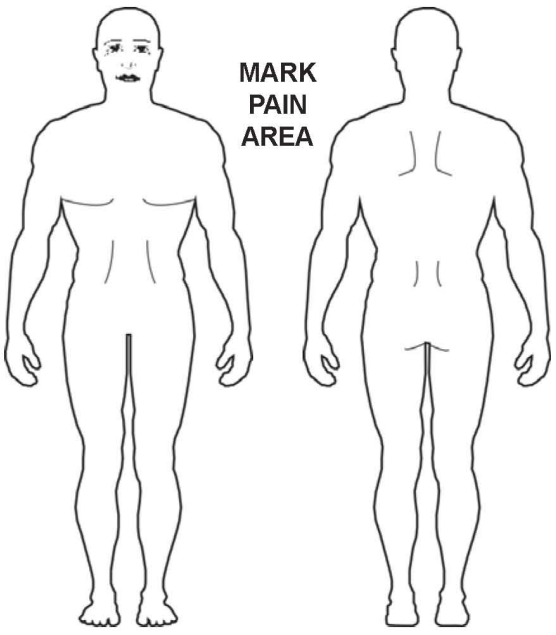
Patient Name: _____ Date: _____
Age: _____ Birth Date: __/__/__ ❑ M ❑ F SS#: _____ Home #:(___)_____ Cell #:(___)_____
Address: _____City: _____ State: ___ Zip: _____

Insured: _____Address: _____
Name of Insurance Company: _____
Have you retained an attorney? ❑ Yes ❑ No Name of Attorney:_____

Date of Accident: __/__/__ Time of Accident: _____ ❑ A.M. ❑ P.M.
Where did the accident happen? _____
Where were you taken after the accident? _____
Where did you feel pain? _____ Were you unconscious? ❑ Yes ❑ No
What are your present symptoms? _____
Are your symptoms: ❑ Improving ❑ Getting Worse ❑ Same ❑ Other _____

Name(s) of any other doctors consulted since your accident: _____
Treatment received: _____
How often was treatment received from the other doctor? _____
Have you previously been injured in a similar manner? ❑ Yes ❑ No

PLEASE EXPLAIN FULLY HOW YOUR ACCIDENT HAPPENED:_____



+++ Burning 000 Stabbing
--- Sharp III Consistant

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Patient/Guardian

Signature:_____ Date:_____