

Patient Information/ PIP

Last Name _____
First Name _____
Middle Name _____
Address _____
City _____
State _____ Zip _____
Home Phone () _____
Work Phone () _____
SS# _____
Birth Date _____
Marital Status _____
Email Address _____

Name of Insured _____
Address _____
City _____
State _____ Zip _____
Nearest Relative _____
Relationship _____
Address _____
City _____
State _____ Zip _____
Phone () _____

Personal Insurance Company _____ Claim # _____
Address _____ Phone () _____
Name on Policy _____

Has the accident been reported to the Insurance Company? __ yes __ no
Date of Accident _____ Time _____ A.M./P.M. Number of Passengers _____
Has an Attorney been retained? __yes __ no If yes, Name of Attorney _____
Address _____ Phone () _____
Have you lost any days of work? __ yes __ no Dates _____
Have you had similar accidents before? __ yes __ no If yes, when? _____

SYMPTOMS YOU'VE NOTICED SINCE THE ACCIDENT:

- | | | |
|--|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Pins and Needles in Legs |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Pins and Needles in Arms |
| <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Depression | <input type="checkbox"/> Numbness in Toes |
| <input type="checkbox"/> Stiff Neck | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Numbness in Fingers |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Mid-back Pain | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Cold Feet |
| <input type="checkbox"/> Low-back Pain | <input type="checkbox"/> Loss of Sleep | <input type="checkbox"/> Cold Hands |
| <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Pain Down Legs | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Tight Muscles | <input type="checkbox"/> Head seems to Heavy | <input type="checkbox"/> Irritability |

Height: _____ Weight: _____

Major Complaint _____

Did you have any of these symptoms before the accident? __ yes __ no
Primary Care Physician _____ Phone () _____

May we contact him or her regarding your care? __ yes __ no
Other Doctors seen for this condition _____

Operations on you Neck or Back? __ yes __ no When? _____ Female- Are you Pregnant? _____

List any medications you are taking _____

Have you ever been to a Chiropractor before? __yes __ no If yes, who? _____

How did you hear about Holmes Chiropractic? __ Newspaper __ Telephone Book __ Internet

Other _____ Referred by _____

Signature

Date

PLEASE TURN PAGE OVER

CIRCLE THE LETTER IN FRONT OF THE APPROPRIATE EXPLANATION

What was your position in the vehicle?

- a The Driver
- b The front passenger
- c The rear passenger
- d A pedestrian

What type of vehicle were you driving?

- a Compact
- b Mid size
- c Full size
- d Other _____

What speed were you traveling at the time of the accident?

- a Complete Stop
- b Slowly merging into traffic
- c Slowing at an intersection
- d Other _____
- e Approximate mph _____

Who hit who?

- a Was struck by another vehicle
- b Struck another vehicle
- c Struck a stationary object

What was your vehicles point of impact?

- a Front: right, left, middle
- b Rear: right, left, middle
- c Side: right front, right rear, right middle
- d Side: left front, left rear, left middle

What speed was the other vehicle traveling?

- a Complete stop
- b Slowly merging into traffic
- c Slowing at an intersection
- d Other _____
- e Approximate mph _____

What was the other vehicles point of impact?

- a Front: right, left, middle
- b Rear: right, left, middle
- c Side: right front, right rear, right middle
- d Side: left front, left rear, left middle

Were you wearing seat restraints?

- a Was wearing full shoulder and lap restraints
- b Was wearing only shoulder restraints
- c Was wearing only lap restraints
- d Wasn't wearing any seat restraints

Did your vehicles airbag deploy?

- a Airbag did deploy
- b Airbag did not deploy

Were you prepared for the impact?

- a Was entirely surprised by the accident
- b Saw the collision coming
- c Saw the collision coming and braced appropriately

What position was your body in just prior to the impact?

- a A straight position
- b A tilted forward position
- c A position rotated to the right
- d A position rotated to the left
- e A position that cannot be remembered

What happened to your body at the moment of impact?

- a Body was tensed for impact
- b Body whipped violently forward and backward
- c Body violently torqued and twisted
- d Body thrown over the seat
- e Body thrown from the vehicle
- f Body was pinned in the vehicle
- g Body was thrown violently from side to side
- h Body was badly cut and bruised

What was your mental/emotional state immediately following the accident?

- a Was not rendered unconscious by the accident
- b Was not rendered unconscious but was shaken and disoriented
- c Was not rendered unconscious but was shaken up
- d Was rendered unconscious by the impact of the accident

Did you receive medical attention at the scene of the accident?

- a Did receive medical attention
- b Did not receive medical attention

Where did you go immediately following the accident?

- a Was taken to a hospital
- b Was taken home
- c Was taken to a personal physician
- d Was taken to this office
- e resumed activities

List each of your body parts that struck the following vehicle parts during the accident:

- Dashboard _____
- Windshield _____
- Steering Wheel _____
- Right Door _____
- Left Door _____
- Seat Frame _____
- Unknown Object _____

Signature

Date