

Trimboli Chiropractic
648 Park Avenue
Huntington, New York 11743
(631) 421-4300

Name _____ Date of Birth _____ Phone _____
Address _____
Employer _____

Your Auto Insurance. Company: _____ Policy # _____
Policyholder Name _____

Have you retained an attorney? () Yes () No If Yes, Attorney & Phone Number _____

Please answer every question.

Nature of Accident:

1. Date of Accident: _____ Time of Day _____
2. Were you: () Driver () Passenger () Front Seat () Back Seat
3. Were you struck from: () Behind () Front () Left side () Right side
4. Were you knocked unconscious? () Yes () No. If yes, for how long? _____
5. Were police notified? () Yes () No
6. In your own words, please describe accident: _____

7. Did you have any physical complaints BEFORE THE ACCIDENT? () Yes () No
If yes, please describe in detail: _____

8. Please describe how you felt:
 - a. DURING the accident: _____
 - b. IMMEDIATELY AFTER the accident: _____
 - c. LATER THAT DAY: _____
 - d. THE NEXT DAY: _____

9. What are your PRESENT complaints and symptoms? _____

10. Do you have any congenital (from birth) factors which relate to this problem?
() Yes () No. If yes, please describe: _____

11. Do you have any previous illnesses which relate to this case? _____ () Yes () No
If yes, please describe: _____

12. Have you ever been involved in an accident before? () Yes () No. If yes, please
describe, including date(s) and type(s) of accidents, as well as injuries received. _____

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13. Where were you taken after the accident? _____

14. Have you ever been treated by another doctor since the accident? () Yes () No.
If yes, please list doctor's name and phone number: _____

If yes, what type of treatment did you receive? _____

15. Since this injury occurred, are your symptoms: () Improving () Getting Worse () Same

16. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

- | | | | | |
|--|---|--|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Irritability | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Feet Cold |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Head seems Too Heavy | <input type="checkbox"/> Depression | <input type="checkbox"/> Fainting | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Lights Bother Eyes | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Diarrhea | |

Symptoms Other Than Above _____

17. Have you lost time from work as a result of this accident?() Yes () No.

If yes, please complete this question.

a. Last Day Worked: _____

b. Type of Employment: _____

c. Are you being compensated for time lost from work? () Yes () No.

If yes, please state type of compensation you are receiving? _____

18. Do you notice any activity restrictions as a result of this injury?() Yes () No.

If yes, please describe, in detail: _____

19. Other pertinent information: _____

Signature

Date: