Accident / Injury Report

Name:_____ Date:_____

Claim #:_____ Date and Time of Injury: _____

Describe what happened: _____

_____

Occupation: _____ Name of Employer: _____

Work Address: _____

Have you missed work due to your injury? _____

Name of hospital or other doctors consulted: _____

In the 5 years prior to this accident, have you;

1. *Taken time off for more than 4 weeks because of a previous injury or health problem?* _____
2. *Used prescription or OTC medications on a regular basis?* _____
3. *Experienced any significant health problems?* _____
4. *Received any Chiropractic or Physiotherapy sessions?* _____
5. *Experienced any problems with anxiety, depression or substance abuse?* _ _____

List *All* Complaints:

SEVERITY

None **Extreme**

0 1 2 3 4 5 6 7 8 9 **10**

Rt.	Lt	Sharp	Dull	
☐	☐	☐	☐	Headaches
☐	☐	☐	☐	Neck Stiffness
☐	☐	☐	☐	Neck Pain
☐	☐	☐	☐	Jaw Pain
☐	☐	☐	☐	Chest Pain
☐	☐	☐	☐	Shoulder Pain
☐	☐	☐	☐	Arm Numbness
☐	☐	☐	☐	Arm Pain
☐	☐	☐	☐	Arm Weakness
☐	☐	☐	☐	Hand Numbness
☐	☐	☐	☐	Hand Pain / Weak

Rt.	Lt	Sharp	Dull	
☐	☐	☐	☐	Pain Between Shoulder Blades
☐	☐	☐	☐	Rib Pain
☐	☐	☐	☐	Low Back Pain
☐	☐	☐	☐	Buttock Pain
☐	☐	☐	☐	Sciatica
☐	☐	☐	☐	Hip Numb / Pain
☐	☐	☐	☐	Thigh Numb / Pain
☐	☐	☐	☐	Knee Pain
☐	☐	☐	☐	Leg Numb / Pain
☐	☐	☐	☐	Leg Weakness
☐	☐	☐	☐	Foot Numb / Pain
☐	☐	☐	☐	Foot Weakness

Other: ☐ Light Headed ☐ Dizzy
☐ Mental Dullness ☐ Lethargic
☐ Ringing in Ears ☐ Other:

Please DRAW Your Complaints