MANLEY & OBBINK CHIROPRACTIC AND ACUPUNCTURE
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Auto Related Accident

Name: _____ Date: _____

Date & Time of Accident: _____ □ a.m. □ p.m.

Were you the: □ Driver □ Front Passenger □ Rear Passenger Ticket Issued? □ Self □ Other □ None

Number of people in your vehicle? _____ Did the police come to the accident site? □ Yes □ No

Was a police report filed? □ Yes □ No Were you wearing your seatbelt at the time of the accident? □ Yes □ No

Were there any witnesses? □ Yes □ No What did you vehicle impact? □ Another vehicle □ Other _____

Was the vehicle equipped with airbags? □ Yes □ No If Yes, did they inflate? □ Yes □ No

In relation to the base of your skull, where was the headrest? □ Above □ Below □ At the base of the skull

Did any part of your body strike anything in the vehicle? □ Yes □ No If yes, explain: _____

Make and Model of the vehicle you were occupying? _____

Name and location/street on which you were traveling? _____

In which direction were you headed? □ North □ South □ East □ West Approx. Speed of your vehicle?_____

Where did the impact to your vehicle occur? □ Front □ Rear □ Right Side □Left Side □ Other

Make and Model of the other vehicle? _____

In which direction was the other vehicle headed? □ N □ S □ E □ W Approx. Speed of other vehicle?_____

Please describe the accident in your own words: _____

_____

Work Related Accident

Date & Time of Accident: _____ □ a.m. □ p.m.

Briefly describe the accident in your own words: _____

_____

Where did the accident occur (include address)? _____

Was anyone else present during your accident? □ Yes □ No Did you properly report the accident? □ Yes □ No

What recommendations were made by your employer after reporting? _____

_____

Has this type of accident happened before? □ Yes □ No Has this happened in your workplace before? □Yes □ No

After Injury

Did the accident render you unconscious? □ Yes □ No If yes, for how long? _____

Please describe how you felt immediately after the accident: _____

_____

Have you gone to the Hospital or seen any other doctors for these injuries? □ Yes □ No

If yes, when did you go? □ Just after accident □ Next day □ 2 days or more By? □ Ambulance □ Private transport

Name of hospital and/or Attending Doctor: _____

Describe any treatment you received: _____

Were x-rays taken? □ Yes □ No Have you been able to work since this injury? □ Yes □ No

Was medication prescribed? □ Yes □ No Has your work been restricted since this injury? □ Yes □ No

Is your condition getting worse? □ Yes □No How often does it occur? □ Constant □ Comes and Goes

Please check all of the symptoms that are a result of this accident:

□ Dizzyness	□ Difficulty Sleeping	□ Jaw Problems	□ Nausea
□ Memory Loss	□ Irritability	□ Arm/Shoulder Pain	□ Back Pain
□ Headaches	□ Numb Hands/Fingers	□ Fatigue	□ Lower Back Pain
□ Blurred Vision	□ Chest Pain	□ Tension	□ Back Stiffness
□ Buzzing in ear	□ Shortness of Breath	□ Neck Pain	□ Leg Pain
□ Ears Ringing	□ Stomach Upset	□ Neck Stiff	□ Numb Feet/Toes

□ Other _____

Please check all of the activities that are painful or uncomfortable to perform (even if only sometimes):

□ Lying on Back	□ Lying on Stomach	□ Lying on Side	□ Sitting
□ Standing	□ Reaching	□ Stretching	□ Lovemaking
□ Walking	□ Running	□ Sports	□ Working
□ Lifting	□ Bending	□ Kneeling	

Have you retained an attorney? □ Yes □ No If yes, whom? _____

Recovery

To evaluate the effect that continuing work will have on your recovery phase, please complete the following:

How many hours are in a normal work day? _____ Is light duty work available to you? □ Yes □ No

Please check any of the following activities you asked to perform for your job (even if occasionally):

□ Standing	□ Sitting	□ Operating Equipment	□ Sitting
□ Twisting	□ Walking	□ Work with arms above head	□ Crawling
□ Typing	□ Lifting	□ Bending	□ Stooping

If any of your medical or account information has changed, please inform our front desk personnel.

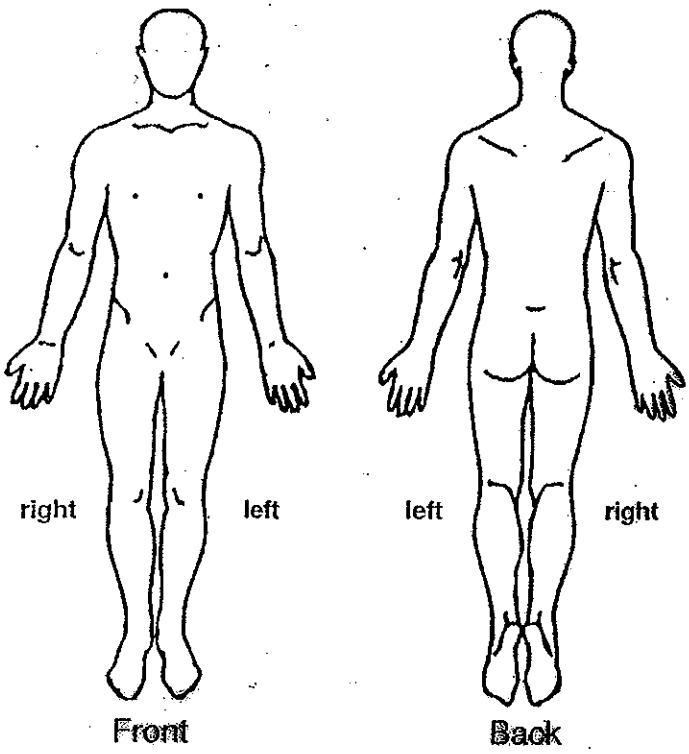
I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

Signature _____ Date _____

Pain Chart

Please indicate areas of pain or discomfort using the appropriate symbols from the chart below:

Numbness	Pins & Needles	Burning	Aching	Stabbing
NNNN	PPPP	BBBB	AAAA	SSSS



Doctor's Notes

- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information that I have provided.

- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize Manley & Obbink Chiropractic and Acupuncture to release any information required to process insurance claims. I agree to be financially responsible for any services submitted to my insurance company if they are deemed to be a non-covered benefit, not medically necessary, or if my insurance benefits have been maxed out.

- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. Any unpaid balance over 90 days of the date of service will be charged 12% interest.

Signature _____ Date ____/____/____

□Adult Patient □Parent or Guardian □Spouse