



Profitt Chiropractic

Call TODAY  
(606) 326-0100

4360, 13th Street, Suite 2, Ashland, KY 41102

### ACCIDENTAL INJURY REPORT (1/3)

Name \_\_\_\_\_ Today's Date \_\_\_\_\_  
Date of Accident \_\_\_\_\_ Time of Accident \_\_\_\_\_ AM PM  
Location of Accident \_\_\_\_\_  
Type of Accident \_\_\_\_\_ Auto/Traffic \_\_\_\_\_ Work/On Job \_\_\_\_\_ At Home  
Other \_\_\_\_\_

Have you lost any time from work because of this accident?  Yes  No If yes, give dates of disability:

Totally disabled from \_\_\_\_\_ to \_\_\_\_\_ Partially disabled from \_\_\_\_\_ to \_\_\_\_\_

Have you returned to work since the accident?  Yes  No

#### VEHICLE YOU WERE IN:

Driver: \_\_\_\_\_  
Insured: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Auto Ins. Co.: \_\_\_\_\_  
Ins. Co. Address: \_\_\_\_\_  
Adjuster: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Policy #: \_\_\_\_\_  
Claim#: \_\_\_\_\_

Have you been contacted by an insurance adjuster or company representative about this accident?  Yes  No

If so, name and phone number of person contacting you: \_\_\_\_\_

Have you retained an attorney?  Yes  No

Date attorney retained or to be retained: \_\_\_\_\_

Attorney's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Were there any witnesses?  Yes  No Names: \_\_\_\_\_

Other pertinent information: \_\_\_\_\_

\_\_\_\_\_

Your vehicle type:  car,  van,  truck,  other \_\_\_\_\_



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### ACCIDENTAL INJURY REPORT (2/3)

Your position in vehicle:  driver,  front passenger,  rear passenger,  other \_\_\_\_\_

What was your vehicle doing at the time of the accident:  moving,  stopped,  turning right/left, \_\_\_\_\_

Time/Speed/Damage: time of accident \_\_\_\_\_, your vehicle's speed \_\_\_\_\_, their speed \_\_\_\_\_, Damage to your vehicle:  mild,  moderate,  totaled

Details of accident/visibility at time of accident:  poor,  fair,  good  
Who hit who/what:  you hit other vehicle,  other vehicle hit you,  you hit (object)

Road conditions at time of accident:  icy,  wet,  sandy,  dark,  clean and dry  
Point of impact:  head-on,  left front/rear,  right front/rear,  rear/end

Body Position, etc.:

Did you see the accident coming:  Yes  No

Were you braced for the impact:  Yes  No

Did you have a seat belt on:  Yes  No

Does your vehicle have headrests:  Yes  No

What was the position of your headrest at the time of the impact:  top of head,  bottom of head,  middle of neck

What was the direction of your head at the time of the impact:  facing forward,  turned to the right,  turned to the left

During the accident:

Did your body strike the inside of your vehicle?  Yes  No

If yes, describe: \_\_\_\_\_

Did you lose consciousness during the injury?  Yes  No

If yes, for how long? \_\_\_\_\_

Your vehicles' estimated damage? \_\_\_\_\_

Did police show up at the scene?  Yes  No

Was an accident report filled out?  Yes  No



**ACCIDENTAL INJURY REPORT (3/3)**

After the accident how did you feel and a few days following: Check those that apply.

- headache       dizziness       nervousness       diarrhea
- neck pain       nausea       loss of taste       depression
- neck stiffness       confusion       toe numbness       anxious
- fainting       fatigue       constipation       chest pain
- unconscious       tension       cold hands
- dazed       irritability
- ringing in ears       mid back pain
- loss of smell       low back pain
- pain behind eyes       shortness of breath       sleeping problems, other: \_\_\_\_\_

Emergency room? Where: \_\_\_\_\_

Where did you go after the accident:  home  work  hospital/ER  private doctor

How did you get there:  drove self  somebody else  ambulance

Were X-rays done?  Yes  No      Was lab work done?  Yes  No

Body parts X-rayed? \_\_\_\_\_ What lab work: \_\_\_\_\_

The X-rays revealed: \_\_\_\_\_

Treatments:  cervical collar  ice  other: \_\_\_\_\_

Medications: \_\_\_\_\_

Follow-up instructions: \_\_\_\_\_

Were you admitted?  Yes  No

**Treatment history:**

Fill in any other doctor(s) seen prior to your first visit to this office.

1. Dr. \_\_\_\_\_ First visit date: \_\_/\_\_/\_\_

Specialty: \_\_\_\_\_ X-rays done?  Yes  No

Types of treatments received: \_\_\_\_\_

How many treatments received? \_\_\_ Currently treating?  Yes  No

Did treatments benefit you?  Yes  No

Last visit date: \_\_/\_\_/\_\_

2. Dr. \_\_\_\_\_ First visit date: \_\_/\_\_/\_\_

Types of treatments received: \_\_\_\_\_

How many treatments received? \_\_\_ Currently treating?  Yes  No

Did treatments benefit you?  Yes  No

Last visit date: \_\_/\_\_/\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_