Rubert Chiropractic
W1185 McCrae Road
Fall River WI 53932
Phone: (920) 484-6444 Fax: (920) 484-6450

AUTO ACCIDENT HISTORY

Name_____Male_____ Female_____
Address_____City_____State_____ Zip Code_____
Home Phone_____Work Phone_____
Text Reminders: YES □ NO □ Cell Phone Provider (needed for text reminder) _____
Date of Birth_____Age_____ Social Security #_____
Date of Accident/Injury _____ Auto □ Other □
Name of Your Auto Insurance_____ Claim #_____
Name of Other Driver_____ His/Her Insurance_____
Ins. Address_____ City_____ State_____ Zip Code_____
Who was at fault? _____ Who was given a ticket? _____
Have you retained an attorney/Do you plan to? YES □ NO □
Were there any witnesses? YES □ NO □

ACCIDENT DETAILS

Were you? Driver _____ Passenger _____ Front Seat_____ Back Seat _____
Number of People in the Vehicle _____ Number of People in Other Vehicle _____
What direction were you headed? North □ South □ East □ West □
Name of the Street: _____
Where was the vehicle struck? Back □ Front □ Left Side □ Right Side □
Were you wearing a seatbelt? YES □ NO □ Were you wearing the shoulder strap? YES □ NO □
Does the car have air bags? YES □ NO □ Were the airbags deployed? YES □ NO □
Were you knocked unconscious? YES □ NO □ If yes, for how long? _____
Were you taken to the hospital/clinic? YES □ NO □ Where? _____
Were the police called? YES □ NO □Is there a report available? YES □ NO □
Have you seen other doctors for this accident? YES □ NO □ Please List: _____
_____
In your own words, please describe the accident: _____
_____
_____
_____
Did you have any physical complaints before the accident? YES □ NO □ If yes, please list: _____
_____
_____

What were your symptoms/complaints…

Immediately after the accident? _____
_____
_____

Later that day? _____
_____
_____

Currently? _____
_____
_____

Since the injury occurred, have your symptoms: Improved ☐ Worsened ☐ Stayed the Same ☐
Do you have any previous illnesses relating to this case? _____
_____

Have you had an accident/injury before? YES ☐ NO ☐ If yes, please list and describe (date, type, etc.):
_____
_____

Do you notice any activity restrictions as a result of the accident/injury? YES ☐ NO ☐ Please describe:
_____
_____
_____

Any other pertinent information:_____
_____
_____
_____

We invite you to discuss frankly with us any questions regarding services. The best health services are based on a friendly, mutual understanding between provider and patient. If your account is not paid within 90 days of the date of service, and no financial arrangements have been made, you will be responsible for any expenses incurred in collecting your account.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in my health or insurance status.

Signature: _____ Date: _____