glow NATURAL HEALTH CENTER, PLLC

Name____ Date of birth____________ Phone________________

Address____ City_________________ State________ Zip_________

Employer's Name______________________________________ Employer's Address______________________________

Your Ins Co____ Policy #______________ Agent's Name_____________

Driver/Other Vehicle___________________________________ Ins Co_________________ Policy #________________

What is your claim number? ____________________________ Do you have Personal Injury Protection? ( ) Yes ( ) No

Have you retained an attorney? ( ) Yes ( ) No Name _______________________________________

Were there any witnesses ( ) Yes ( ) No Names _______________________________________

NATURE OF ACCIDENT:

Date of Accident__________________ Time of Day ________________ City & State _____________________________

Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat

Number of people in your vehicle? ________________ Other vehicle? ___________________

What direction were you headed? ( ) North ( ) East ( ) South ( ) West

On (name of street) ____

What direction was other vehicle headed? ( ) North ( ) East ( ) South ( ) West

On (name of street) ____

Were you struck from: ( ) Behind ( ) Front ( ) Left side ( ) Right side

Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long?______________________________

Were police notified? ( ) Yes ( ) No

In your own words, please describe accident:

____

____

____

Did you have any physical complaints BEFORE THE ACCIDENT? ( ) Yes ( ) No

If yes, please describe in detail:

____

____

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Please describe how you felt:

DURING the accident: ____

IMMEDIATELY AFTER the accident: ____

____

LATER THAT DAY: ____

THE NEXT DAY: ____

What are your PRESENT complaints and symptoms? ____

____

____

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Do you have any congenital (from birth) factors which relate to this problem? ( ) Yes ( ) No

If yes, please describe: ______________________________

Do you have any previous illnesses which relate to this case? ( ) Yes ( ) No

If yes, please describe: ______________________________

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:

____

____

Where were you taken after the accident? ______________________________

Have you been treated by another doctor(s) since the accident? ( ) Yes ( ) No

If yes, please list doctor's name and phone number: ______________________________

____

What type of treatment did you receive? ______________________________

____

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

CIRCLE SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT

Headache	Irritability	Numbness in Toes	Face Flushed	Feet Cold
Neck Pain	Chest Pain	Shortness of Breath	Buzzing in Ears	Hands Cold
Neck Stiff	Dizziness	Fatigue	Loss of Balance	Stomach Upset
Sleeping Problems	Head Seems Too Heavy	Depression	Fainting	Constipation
Back Pain	Pins & Needles in Arms	Lights bother Eyes	Loss of Smell	Cold Sweats
Nervousness	Pins & Needles in Legs	Loss of Memory	Loss of Taste	Fever
Tension	Numbness in Fingers	Ears Ring	Diarrhea	Anxiety

Symptoms Other Than Above ______________________________

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

If yes, please describe, in detail: ______________________________

____

____

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

If yes, please fill out the following:

Last Day Worked: ____________ Type of Employment: ______________________

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

If yes, please state type of compensation you are receiving: ______________________

Other pertinent information:

____

____

Signature ______________________________ Date: ____________

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