

Frank Chiropractic Center

Harvey A. Frank D.C.

Phone: (954) 467-1900

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PERSONAL INJURY CONSULTATION

Name: _____ Pt.# _____ Today's Date: _____

Address: _____

Date of Accident: _____

Claim #: _____

Soc. Security #: _____

Attorney's Name: _____ Phone: _____

_____ Fax #: _____

_____ Contact: _____

Employer Name: _____ Phone : _____

_____ Fax #: _____

_____ Contact: _____

Insurance Name: _____ Phone : _____

_____ Fax #: _____

_____ Adjuster: _____

Year & model of your vehicle: _____.

Year & model of other vehicle: _____.

Approximate damage to your vehicle: _____.

Description of Accident: (include any unusual circumstances)

Use this space to illustrate accident:

(Do the best you can to create a drawing of the accident)

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Circle ALL the correct answers

Were you a pedestrian? *Yes No* Were you riding a bicycle? *Yes No*
 Did you see the accident coming? *Yes No* Did you brace for impact? *Yes No*
 Were you wearing your seat belt? *Yes No* Did your vehicle have air bags? *Yes No*
 Did air bag open? *Yes No* If yes, driver's side/ passenger side. Was your car moving? *Yes No*
 Estimate speed of your vehicle ____ mph. Estimate speed of other vehicle ____ mph.
 Damage to your vehicle \$ _____
 You were sitting: *driver's seat front passenger rear driver middle rear rear passenger*
 Any bodily impact within your vehicle: _____
 As a direct result of the accident, you were: *unconscious dazed in shock* other: _____

Past History (before this accident)

In the past have you had any of the same or similar complaints that you now have that are the result of this accident that required treatment? **YES NO**

If the answer is **YES**, explain area(s) of complaint, dates of service, the doctor's name & specialty that treated you and the type of care received and if related to an accident or injury. *(Please write on the back if more space is needed.)*

1. Area of complaint: _____
 Dates of service (from when to when), doctor's name & specialty, care received (accident YES NO)

2. Area of complaint: _____
 Dates of service (from when to when), doctor's name & specialty, care received (accident YES NO)

3. Area of complaint: _____
 Dates of service (from when to when), doctor's name & specialty, care received (accident YES NO)

4. Area of complaint: _____
 Dates of service (from when to when), doctor's name & specialty, care received (accident YES NO)

1321 South Andrews Avenue; Ft. Lauderdale, FL 33316

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Activities of Daily Living

Are you able to do all that you could or would want to do as compared to how you were prior to this accident? Regarding work, home AND play, list and briefly describe all activities that have been affected as a result of this accident: _____

Employment

Employer at time of accident: Name: _____

Address: _____

Phone _____ Fax #: _____

Supervisor's Name: _____ Job Title: _____

Job responsibilities: _____

Hours per day sitting: _____ Hours per day standing: _____ How much & what type of lifting does your job require? _____

Since this accident you have (check off and fill in all that apply):

- Missed no days of work and I am able to work with no restrictions.
- Missed no days of work; however I am only able to work with restrictions. My restrictions include: _____.
- Missed _____ days of work since date of accident.
- Unable to work since date of accident.
- Totally disabled from _____ to _____ Partially disabled from _____ to _____.