

HOWARD CHIROPRACTIC
808 WHITE RIVER BLVD.
MUNCIE, IN. 47303
765-254-9481

16. Have You Ever Been Involved in an Accident Before? () Yes () No
If Yes, Please Describe, Include Any Dates and Types of Accidents, as Well as Injuries Received: _____

17. Have You Been Treated by Another Doctor Since The Accident? If Yes, Please List:
What Kind of Treatment Did You Receive? _____

18. Since This Accident Occurred, Are Your Symptoms:
() Improving () Getting Worse () The Same

19. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

- () Headache () Irritability () Numbness in Toes () Face Flushed () Feel Cold
() Neck Pain () Sleeping Problems () Shortness of Breath () Buzzing of Ears () Hands Cold
() Neck Stiff () Dizziness () Fatigue () Loss of Balance () Upset Stomach
() Chest Pain () Head Seems Heavy () Depression () Fainting () Constipation
() Back Pain () Pins & Needles in legs () Pins & Needles in arms () Loss of Smell () Cold Sweats
() Nervousness () Light Bothers Eyes () Loss of Memory () Loss of Taste () Fever
() Tension () Numbness in Fingers () Ears Ring () Diarrhea

Symptoms Other Than Above: _____

20. Have You Lost Time From Work as a Result of This Accident? () Yes () No
If Yes please complete these questions:

A. Last Day Worked: _____

B. Type of Employment: _____

C. Present Salary: _____

D. Are You Being Compensated for Time Lost From Work? () Yes () No

If yes, Please State Type of Compensation You are Receiving: _____

21. Do You Notice Any Activity Restrictions as a Result of This Injury? () Yes () No
If Yes, Please Describe in Detail _____

22. Other Pertinent Information _____

Your Insurance Company Name _____

Address _____

Agents Name _____ Policy Number _____

Phone Number _____

Has a Claim Been Opened on This Accident? () Yes () No

Driver/Other Vehicles Name _____

His/Her Insurance Company _____

His/Her Agent's Name _____ Policy Number _____