

Sterling Rock Falls Clinic, Curtis H. Coyle, D.C.
ACCIDENTAL INJURY FORM

NAME _____ DATE _____

Date of Accident _____ Time: ___ am ___ pm Location of Accident _____

AUTO INJURY

Were You: () Driver () Passenger () Pedestrian

Were you struck from: () Behind () Right Side () Left Side () Front () Parked

Did your car strike the others involved: () Yes () No () Undetermined

Did the other car strike yours: () Yes () No () Undetermined

As a result of the Accident, were traffic citations issued to you? () Yes () No

OTHER

Describe the circumstances of the accident (Be Specific) _____

CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT

- | | | | |
|-----------------|----------------------------|------------------------|-------------------|
| () Headache | () Sleeping Problems | () Lights Bother Eyes | () Diarrhea |
| () Neck Pain | () Head Too Heavy | () Loss of Memory | () Feet Cold |
| () Neck Stiff | () Pins & Needles in | () Ears Ringing | () Hands Cold |
| () Dizziness | Arms | () Face Flushed | () Stomach Upset |
| () Back Pain | () Pins & Needles in Legs | () Buzzing in Ears | () Constipation |
| () Nervousness | () Numbness in Fingers | () Loss of Balance | () Cold Sweats |
| () Tension | () Numbness in Toes | () Fainting | () Fever |
| | () Shortness of Breath | () Loss of Smell | () Other |
| | () Fatigue | | |

Did you require post-accident hospitalization? () Yes () No
Have you lost any days of work? () Yes () No If Yes (dates), _____ through _____

INSURANCE INFORMATION

Other Party's Name _____ Address _____

Other Party's Ins. Co. _____ Address _____

Your Auto Insurance Company _____ Address _____

Claim Number _____ Agents Name _____

Have you been contacted by an insurance adjustor regarding this claim () Yes () No

If yes, name of adjustor _____ Company _____

Do you have an attorney that has advised you in this case: () Yes () No

If yes, attorney's name _____ Phone number _____

Attorneys address _____

I HEREBY AUTHORIZE THE SRFC TO RELEASE ANY INFORMATION ACQUIRED DURING EVALUATION OR TREATMENT FOR THIS INJURY TO THE ABOVE MENTIONED REPRESENTATIVES

Signature_____