



Griffin Chiropractic & Wellness Center, P.A.

4200 S.W. Green Oaks Blvd, Suite 100 Arlington, TX 76017

Phone: (817) 478-5800 Fax: (817) 478-5803

ACCIDENT/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

Were you wearing your seatbelt? () Yes () No

Did the airbags deploy? () Yes () No

Did you receive medical attention at the scene of accident? () Yes () No

How fast were you travelling? _____mph Other vehicle? _____mph

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 Arms | () Ears Ringing | () Hands Cold |
| () Dizziness | () Pins & Needles in Legs | () Face Flushed | () Stomach Upset |
| () Back Pain | () Numbness in Fingers | () Buzzing in Ears | () Constipation |
| () Nervousness | () Numbness in Toes | () Loss of Balance | () Cold Sweats |
| () Tension | () Shortness of Breath | () Fainting | () Fever |
| () Irritability | () Fatigue | () Loss of Smell | () Other |
| () Chest Pain | () Depression | () Loss of Taste | |

Did you require post-accident hospitalization or medical attention? () Yes () No

Have you lost any days of work? () Yes () No If Yes, _____ through _____

INSURANCE INFORMATION

Your Auto Insurance Co. _____ Address _____

Other Party's Name _____ Address _____

Other Party's Ins. Co. _____ Address _____

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

If yes, name of adjustor _____ Company _____

Claim Number: _____ Phone Number: _____

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

Signature _____