Belleville Chiropractic and Wellness Center
PH: (608) 424 1840

1100 Bellwest Blvd
Belleville, WI 53508
Fax: (608) 424 1815

PERSONAL INJURY FORM

Personal Information	
Name:	
DOB:	
Age:	
Phone:	
Address:	
S/S #	
Employer Information	
Company:	
Address:	
Insurance Information	
Company:	
Policy #:	
Policy Holder:	
Attorney Information	
Name:	
Phone:	
Address:	

Accident Information		
Were there witnesses:	Yes [ ] No [ ]	
Responsible party's name:		
Responsible party's address:		
Date/Time of accident:		
Were you:	Driver [ ] Passenger [ ] Front Seat [ ] Back Seat [ ]	
Number of people in the vehicle:		
Were seatbelts being worn?	Yes [ ] No [ ]	
What direction were you headed:	North [ ] South [ ] East [ ] West [ ]	
Street name you were driving on:		
Direction of other vehicle:	North [ ] South [ ] East [ ] West [ ]	
Were you struck from:	Behind [ ] Front [ ] Left [ ] Right [ ]	
Approx. speed of your car: _____MPH		Approx. speed of other car: _____MPH
Were you knocked unconscious:	Yes [ ] No [ ] If yes, for how long: _____	
Were police notified:	Yes [ ] No [ ]	

In your own words, please describe the accident:

Any physical complaints before the accident?	
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:	
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 [ ]
Is yes, please describe	
Have you ever been involved in an accident before?	Yes [ ] No [ ]
If yes, please describe type of accident(s) including dates and injuries	
Where were you taken after the accident	
Have you been treated by another doctor since the accident?	Yes [ ] No [ ]
If yes, list name and address:	
What type of treatment did you receive?	
Since this injury occurred, are your symptoms:	Improving [ ] Getting worse [ ] The Same [ ]

Check symptoms you have noticed since the 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
[ ] Problems sleeping	[ ] Head feels heavy	[ ] Depression	[ ] Fainting	[ ] Constipation
[ ] Back pain	[ ] Pins/needles in arms	[ ] Lights bother eyes	[ ] Loss of smell	[ ] Cold sweats
[ ] Nervousness	[ ] Pins and needs in legs	[ ] Loss of memory	[ ] Loss of taste	[ ] Fever
[ ] Tension	[ ] Numbness in fingers	[ ] Ears ringing	[ ] Diarrhea	[ ] Other
Symptoms other than above:				
Do you notice any activity restrictions as a result of this injury?			Yes [ ]	No [ ]
If yes, please describe:				
Other pertinent Information:				

Signature: _____ Date: _____