Personal / Home Injury History
Advanced Chiropractic of Conyers

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Patient Name: _____ Date: _____

Age: _____ Birth Date: _____/ _____ / _____ ❑ M ❑ F S.S.#: _____

Address: _____

City: _____ State: ___ Zip: _____Driver's License #:_____

Insured: _____Address: _____

Name of Insurance Company:_____

City: _____ State: _____Zip: _____ Telephone #:_____

(If home injury, Home Owner's Policy may be responsible for payment.)

Have you retained an attorney? ❑ Yes ❑ No Name of Attorney: _____

Address of Attorney: _____

Date of Accident: _____ / _____ / _____ Time of Accident:_____ ❑ A.M. ❑ P.M.

Where did the accident happen?_____

Where were you taken after the accident? _____

Where did you feel pain?_____ Were you unconscious? ❑ Yes ❑ No

What are your present symptoms? _____

Are your symptoms: ❑ Improving? ❑ Getting Worse? ❑ Same? ❑ Other? _____

Name(s) of any other doctors consulted since your accident:_____

Treatment received:_____

How often did you receive treatment from the other doctor?_____

Have you previously been injured in a similar manner? ❑ Yes ❑ No

PLEASE EXPLAIN FULLY HOW YOUR ACCIDENT HAPPENED: _____

_____

_____

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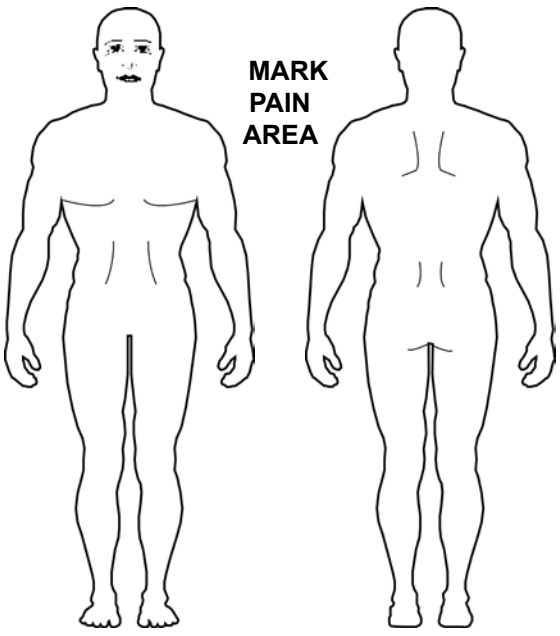
_____

_____

Date: _____Patient Signature: _____

Date: _____Patient Signature: _____

_____



+++ Burning 000 Stabbing
--- Sharp III Consistent