



**Family Chiropractic
& Occupational
Health Services**

Dr. Gary L Sash, D.C., M.S.
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Accident Incident and Injury Form

Patient _____ Address _____

City _____ State _____ Zip _____

Phone Number _____ Email _____

*** Date of Patient's First Visit (regarding this case) _____

- Automobile Accident
 Pedestrian
 Injury at Home
 Worker's Compensation
 Other _____

Previous Treatment for this injury

Emergency treatment at _____ Date _____

Hospitalized at _____ Date _____

Doctor _____ Specialty _____ Date _____

Address _____ City _____ State _____ Zip _____

Treatments or Remarks _____

History

Date of Injury _____ Time _____

Location of place of injury _____

Patient's Description of how the accident occurred _____

What happened to the patient on impact? _____

Was the patient thrown or tossed about? _____

Did the patient's body strike any particular object? _____

Was the patient using seat belts or restraints? Yes No

Congenital factors bearing on this case _____

Previous illnesses with residuals bearing on this case _____

Residual problems from previous accidents _____



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Present Injury

Patient's Complaints

1. Headaches (describe) _____
2. Blurred Vision 3. Dizziness 4. Nausea 5. Difficulty Breathing
6. Vomiting 7. Fatigue 8. Difficulty Sleeping 9. Nervousness
10. Depression 11. Memory Lapses 12. Dyspathy 13. Megrims
14. Neck Pains left middle right
15. Shoulder Pains left middle right
16. Mid Back Pains left middle right
17. Low Back Pains left middle right
18. Other