Windward Family Wellness Center & Kailua Chiropractic

Dr. Shayne M. Guthrie, D.C. ***Dr. Scott Horowitz, D.C.***

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ACCIDENT REPORT

Name _____ Date of Injury/Accident _____

Insurance _____ Claim Number _____

Insurance Address _____ City/State/Zip Code _____

Adjuster _____ Adjuster's Phone/Fax _____

Briefly describe where and how the accident occurred: _____

_____

_____

_____

Briefly describe injuries and symptoms immediately following the accident: _____

_____

_____

Briefly describe injuries and symptoms within 24 to 48 hours after the accident _____

_____

_____

Were you treated by another doctor for this injury? If yes, who (please describe treatment and include date of treatment)? _____

_____

_____

_____

Were you hospitalized? If yes, where (please include date of admission and date of discharge)? _____

_____

_____

Did your accident result in a disability for work? _____ Yes _____ No

Date disability began _____

Signature _____ Date _____