AMON CHIROPRACTIC &
WELLNESS CENTER **DR. SHEILA AMON**

10605 Concord Street, Suite 502 240-242-3266
Kensington, Maryland 20895 (fax) 240-242-3248

ACCIDENT INFORMATION

NAME_____
Was your injury work related _____ or auto accident ____?
Date and Time of Injury _____
If this is work related, did you tell your employer/foreman: ___Yes ___No
Location of the Accident_____
Driver _____ or Passenger _____

Please describe in your own words how the accident occurred: _____

_____

_____

_____

Please check any of the symptoms below that apply to your injury:

Neck stiffness _____	Neck Pain _____	Headaches _____	Stiffness ___
Low Back Pain _____	Low Back Stiffness _____		Back Spasms ____
Upper Back Pain ___	Upper Back Stiffness ____		Fatigue _____
Head Feels Heavy___	Tingling/Numbness _____		Sleeplessness____

Please describe any other symptoms that you might have following this accident:_____

_____

_____

INSURANCE INFORMATION:

Your Car Insurance Company:_____
Address _____
Adjuster/Case Manager_____
Policy #:_____ Phone #_____
Claim #_____

WC Carrier:_____
Address _____
Claim #:_____ Phone #_____

Attorney Name/Address/Phone #_____

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