Michael D. Hanley, D.C.

Patient Demographics

Name:_____ Date: _____

Street Address:_____

City: _____State: _____ Zip Code: _____

Social Security Number: _____ Driver's License#: _____

Sex: M/F Marital Status: M S D W Name of Spouse: _____

Race: _____ Date of Birth:_____

Contact Information (check preference)

[] Home#_____ [] Cell# _____ [] Work#_____

E-mail address: _____

Emergency Contact:_____Phone#_____

Name of Employer:_____

Employer Address: _____

Occupation: _____

How were you referred to this office: _____

Type of Case

____ Private Insurance ____ Work Compensation ____ Cash

____ Personal Injury ____ Medicare

Insurance Information

Insurance Name:_____ Phone#:_____

Policy Holder Name_____DOB_____

Policy#:_____ Claim#: _____

Adjustor/Agent Name_____

Copy of Insurance Card:

Michael D. Hanley, D.C.

Accident/Injury Questionnaire

Name:_____ Date: _____ PT#:_____

Have you retained an Attorney? [] Yes [] No Name:_____
Address: _____Phone#: _____

Please list names of any witnesses: _____

Accident Information

Date of Accident:	**Time: am pm**
Conditions (please circle): DRY WET ICY SNOW MUDDY	

Description of accident in your words:

Mechanism of Injury (please check all that apply)

	Vehicle		**Struck right side**
	Motorcycle		**Struck left side**
	Pedestrian		**Right hand on steering wheel**
	Driver		**Both hands on steering wheel**
	Front seat passenger		**Left hand on steering wheel**
	Rear seat passenger		**Air bag deployed**
	Wear lap and strap support seat belt		**No air back deployed**
	Was unrestrained		**Vehicle had no air bag**
	Passenger side impact		**Police and ambulance present**
	Driver side impact		**No police report**
	Rear impact		**Car spun upon impact**
	Frontal impact		**Car rolled**

Did any part of your body strike anything:
Example: Left side of head hit window / Forehead hit steering wheel
Please explain: _____
_____

How did you feel at time of accident:

	Unconsciousness	**How long:**		**Dizziness**	**How long:**
	Dazed	**How long:**		**Nauseated**	**How long:**
	Confusion	**How long:**		**Vomiting**	**How long:**
	Headache	**How long:**		**Other:**	**How long:**

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How did you leave the accident site:

	Drove
	Ambulance
	Friend
	Husband
	Wife
	Daughter
	Son
	Family Member
	Other:

Where did you go:

	Went to ER
	Went to work
	Went to home
	Other:

Treatment that you received at the hospital / ER:

List other Doctors seen and/or tests that you have received for this accident:

Doctor or Test	Date