Bonnie M. Abel Bolash, M.Ac., L.Ac.
Licensed Acupuncturist
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PERSONAL & AUTO INJURY INFORMATION

Patient Information

Name:_____ Date of Birth: _____
(PLEASE PRINT NAME)

Accident and Health Information

Accident Date / / Was a Police or State Patrol report made? YES / NO

Accident Location_____

Were you the: ☐Driver ☐Passenger ☐Other_____ Were you injured? YES / NO

Describe the accident: _____

Were you taken to a hospital? YES / NO Hospital Name_____ Were you hospitalized? YES / NO

What are your present complaints?_____

Have you noticed any restrictions to activities to daily living since the Accident? YES/NO If yes, please describe:

_____

Was there anyone else in the accident with you? YES / NO If yes, who? _____

Additional Providers you have seen for treatment from this accident

What treatments have you received to this point? _____

Provider's Name_____ Phone _____

City/State_____ Type of Care: _____

Provider's Name_____ Phone _____

City/State_____ Type of Care: _____

Did you miss any time from work? YES / NO If yes, how much? _____

Have you returned to your same job? YES / NO If not, why? _____

Claim Information

Are you represented by an attorney? YES / NO Attorney's Name _____

Attorney's address _____

Insurance Company Name_____ Claim #_____

Adjuster's Phone #_____ Policy #_____

Claims Address _____