

Enos Chiropractic Clinic
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Doctor of Chiropractic

9739 Flower Street
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Date: _____

Name: _____

Date of Collision: _____

Previous accidents (include year, did you have treatment):

Previous work injuries (include year, did you have treatment):

Surgeries or hospitalizations in the past (include year).

Did you go to the Hospital, Urgent Care or any other doctor for this injury, if so which one and what did they do?

Medications you are taking for the pain. _____

Did you have any pain prior to the collision? _____