Auto Accident Information

ALL INFORMATION IS CONFIDENTIAL

Patient Name _____ **Date** / / _____ **Account #** _____

Insurance Information

Part 1

Insurace Company:

Date of Accident:

Address:

Time of the Accident : AM PM

City: **State:** **ZIP:**

Claim #:

Case/Claim Contact Person:

Phone #: ( ) -

Accident Information

Part 1

Your Position in the Vehicle:

☐ Driver ☐ Front Passenger ☐ Rear Passenger, driver's side ☐ Rear Passenger, middle seat ☐ Rear Passenger, passenger's side

Your Vehicle Type:

☐ Compact Car ☐ Mid-size Car ☐ Full size Car ☐ Compact Truck ☐ Full Truck ☐ Semi Truck

☐ Mini Van ☐ Full-size van ☐ Small Sport Utility ☐ Lrg. Sport Utility ☐ Motorcycle ☐ Other:

What was YOUR vehicle doing at the time of the accident?

☐ Stopped at a stop sign ☐ Parked ☐ Making a right turn ☐ Accelerating

☐ Stopped in traffic ☐ Proceeding along ☐ Making a left turn ☐ Slowing down

☐ Stopped at a light ☐ Changing lanes

Your Vehicle Speed MPH

Their Vehicle Speed MPH

Part 2

Road Conditions at the Time of the Accident *(mark all that apply)* :

☐ Dry ☐ Wet ☐ Icy ☐ Snowy ☐ Foggy ☐ Sandy ☐ It was dark

Visibility at the Time of the Accident:

☐ Poor ☐ Fair ☐ Good ☐ Excellent

Who Hit Who or What?

☐ You hit the other vehicle ☐ The other vehicle hit yours ☐ You hit..(object):

Point of Impact (where did your car get hit?)

☐ Head-on ☐ Right Front ☐ Left Front ☐ Right Side ☐ Left Side ☐ Rear-end ☐ Right Rear ☐ Left Rear

Awareness of Accident: Did you see the accident coming? ☐ Yes ☐ No Were you braced for the impact? ☐ Yes ☐ No

Damage to YOUR vehicle: ☐ Minimal ☐ Mild ☐ Moderate ☐ Considerable (totaled)

Part 3

Seatbelt

Did you have your seatbelt on? ☐ Yes ☐ No

What was the direction of your head at the time of the impact?

☐ Facing Forward ☐ Turned to the right ☐ Tilted right

☐ Looking rearward ☐ Turned to the left ☐ Tilted left

Air Bag Deployment

Did the driver side air bag deploy? ☐ Yes ☐ No

Did the passenger side air bag deploy? ☐ Yes ☐ No

Did the side air bags deploy? ☐ Yes ☐ No

Hit in the Car:

Did any part of your body strike or hit any part of the inside of your vehicle? ☐ Yes ☐ No

If yes, please decribe (i.e. my head hit the steering wheel):

Did you lose consciousness during or after the accident? ☐ Yes ☐ No If Yes, for how long?

Did the police show up at the scene? ☐ Yes ☐ No **Was an accident report filed?** ☐ Yes ☐ No

After the Accident

Part 4

Mark ALL the symptoms you had right after (or a few days after) the accident:

☐ headache ☐ neck stiffness ☐ neck pain ☐ mid-back pain ☐ low back pain ☐ chest pain ☐ pain behind eyes

☐ anxiety ☐ confusion ☐ dizziness ☐ nausea ☐ irritability ☐ fanting ☐ tension

☐ cold hands ☐ cold feet ☐ ringing in ears ☐ loss of smell ☐ loss of taste ☐ constipation ☐ diarrhea

☐ sleeping problems ☐ depression ☐ muscle soreness ☐ muscle pain ☐ toe numbness ☐ shortness of breath

☐ other *(please describe)* :

Where did you go after the accident?

☐ Home ☐ Work ☐ Hospital ER ☐ Private Doctor

How did you get there?

☐ Drove self ☐ was provided a ride ☐ taken by ambulance ☐ taken by police

X-rays Taken? ☐ Yes ☐ No *(if yes, what did they find?)*

Patient Name | **Date** / / | **Patient File #**

Emergency Care Treatment:

Part 4

Treatments (i.e. cervical collar, ice, stitches, etc.):

Medication Given (i.e. painkillers, etc.):

Follow-up instructions (i.e. stay off your feet, etc.):

Treatment History (Fill in any other doctors you have seen prior to your visit to this office for this accident)

Part 5

Prior Treatment From:
☐ Emergency room doctor ☐ Family Doctor ☐ other healthcare provider

Date of first Visit: / /

Specialty:
☐ Neurology ☐ Orthopedic medicine ☐ Chiropractic ☐ Family Doctor ☐ Osteopathy ☐ Naturopath ☐ Other:

Diagnostic Tests: ☐ CT scan ☐ MRI ☐ X-ray *Findings:*

Types of Treatment Received:
☐ Medication ☐ Chiropractic Treament ☐ Physical Therapy ☐ Surgery ☐ Exam only ☐ Other:

Are you currently being treated by this practitioner? ☐ Yes ☐ No

Did (or do) the treatments benefit you? ☐ Yes ☐ No

How many treatments have you received:

Date of last visit: / /

Part 6

Prior Treatment From:
☐ Emergency room doctor ☐ Family Doctor ☐ other healthcare provider

Date of first Visit: / /

Specialty:
☐ Neurology ☐ Orthopedic medicine ☐ Chiropractic ☐ Family Doctor ☐ Osteopathy ☐ Naturopath ☐ Other:

Diagnostic Tests: ☐ CT scan ☐ MRI ☐ X-ray *Findings:*

Types of Treatment Received:
☐ Medication ☐ Chiropractic Treament ☐ Physical Therapy ☐ Surgery ☐ Exam only ☐ Other:

Are you currently being treated by this practitioner? ☐ Yes ☐ No

Did (or do) the treatments benefit you? ☐ Yes ☐ No

How many treatments have you received:

Date of last visit: / /

Please write any other details of your accident that have not been included:

Signature (Patient / Guardian / Responsible Party)

Today's Date: