Auto Accident Form

Patient Name: ____ Today's Date: ___/___/_____

Date of Accident: ___/___/_____

Have you filed a report with your insurance company? ☐ Yes ☐ No

Carrier: __________________________________ Policy Number: _____________________

Carrier's Phone Number: (_____)-_______-_____ Adjuster: _________________

Claim Number: ______________________

Have you retained an attorney to represent you in this case? ☐Yes ☐No

If yes, who? ____________________________ Attorney's Phone Number: (_____)-_____-_____

Please mark your involvement in the auto accident: ☐Pedestrian ☐Driver ☐Passenger

What are your current symptoms? ☐Pain ☐Numbness ☐Stiffness ☐Weakness

Did you have any pain before the accident? ☐Yes ☐No

If yes, please list areas of complaint before the accident: _________________________________

____

Were you knocked unconscious? ☐Yes ☐No

Describe in your own words what happened during the accident: __________________________

____

____

Patient was located: ☐Driver ☐Passenger-Middle Front ☐Passenger-Right Front

☐Passenger-Left Rear ☐Passenger-Middle Rear ☐Passenger-Right Rear

Patient Vehicle Type: ☐Compact ☐Mid-Size ☐Full-Size ☐SUV ☐Pick-Up ☐Motorcycle

☐Tractor Trailer

Second Vehicle Type: ☐Compact ☐Mid-Size ☐Full-Size ☐SUV ☐Pick-Up ☐Motorcycle

☐Tractor Trailer

Were there more vehicles involved? ☐Yes ☐No If yes, please describe: _____________________

____

Road Conditions: ☐Clear ☐Dark ☐Dry ☐Foggy ☐Icy ☐Wet

Road Type: ☐Asphalt ☐Concrete ☐Dirt ☐Gravel

Were you wearing a seatbelt? ☐Yes ☐No

Did your airbag deploy? ☐Yes ☐No

Does your seat have a head rest? ☐Yes ☐No

If yes, what position was your headrest in? ☐Up ☐Middle ☐Down

Patient's head position: ☐Looking straight ahead ☐Left level ☐Left up ☐Left down ☐Right level

☐Right up ☐Right down ☐Looking up ☐Looking down

Accident Details:

Was your car braking? ☐Yes ☐No Was your car moving? ☐Yes ☐No

If yes, how fast? ☐<5 ☐6-10 ☐11-15 ☐16-20 ☐21-30 ☐31-40 ☐41-50 ☐51-60 ☐61-70 ☐>70

Was the second vehicle braking? ☐Yes ☐No Was the second vehicle moving? ☐Yes ☐No

If yes, how fast? ☐<5 ☐6-10 ☐11-15 ☐16-20 ☐21-30 ☐31-40 ☐41-50 ☐51-60 ☐61-70 ☐>70

Was the third vehicle braking? ☐Yes ☐No Was the third vehicle moving? ☐Yes ☐No

If yes, how fast? ☐<5 ☐6-10 ☐11-15 ☐16-20 ☐21-30 ☐31-40 ☐41-50 ☐51-60 ☐61-70 ☐>70

Auto Accident Form

ADVANCED CHIROPRACTIC Health & Wellness Center

Collison Details:

First Impact: ☐Hit by other vehicle ☐Hit other vehicle ☐Hit by object ☐Hit object

Impact Location: ☐Front ☐Front-Right ☐Front-Left ☐Left

☐Right ☐Rear-Right ☐Rear-Left ☐Rear ☐Top

Second Impact: ☐Hit by other vehicle ☐Hit other vehicle ☐Hit by object ☐Hit object

Impact Location: ☐Front ☐Front-Right ☐Front-Left ☐Left

☐Right ☐Rear-Right ☐Rear-Left ☐Rear ☐Top

Collison Results:

Body was thrown: ☐Forward ☐Backward ☐Left ☐Right ☐Cannot remember

Head Hit: ☐Airbag ☐Front Windshield ☐Rearview Mirror ☐Headrest

☐Steering Wheel ☐Dashboard ☐Back of seat ☐Side Window/Door ☐Another person's body

Chest Hit: ☐Airbag ☐Steering Wheel ☐Dashboard ☐Back of the front seat

☐Side Window/Door ☐Another person's body

Shoulders Hit: ☐Shoulder Harness ☐Side Window/Door ☐Back of front seat

☐Another person's body

Knees Hit: ☐Steering Wheel ☐Dashboard ☐Dashboard ☐Back of front seat ☐Door panel

☐Center console ☐Another person's body

Vehicle Damage:

Patient Vehicle: ☐Totaled ☐Significant Damage ☐Light Damage ☐No Damage

Second Vehicle: ☐Totaled ☐Significant Damage ☐Light Damage ☐No Damage

Third Vehicle: ☐Totaled ☐Significant Damage ☐Light Damage ☐No Damage

Hospitalization:

Did you go to the hospital? ☐Yes ☐No If yes, please answer the following questions:

Were you hospitalized? ☐Yes ☐No

When were you hospitalized? ☐Immediately ☐Later same day ☐Next day ☐Date: ___/___/___

How were you transported to the hospital? ☐Ambulance ☐Life Flight ☐Private transportation

What did the hospital recommend? ☐No instructions ☐See this clinic ☐See a DC ☐See own doctor

☐See Orthopedist ☐See Neurologist ☐Prescription medication ☐Other: ______________________

Did you have x-rays taken? ☐Yes ☐No

If yes, what areas? ____

I hereby state that the information provided by me is accurate and whole.

Print Name: _____________________ Patient's Signature: _____________________ Date: ___/___/_____