AUTO ACCIDENT INFORMATION

Date and time of accident _____ ☐ AM ☐ PM

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger Number of People in Accident Vehicle: _____

Make and model of the vehicle you were in? _____

YOUR Auto Insurance Company:_____Claim #_____

Adjuster Name:_____Adjuster Phone #_____Email:_____

Is there Med Pay on this plan? ☐ Yes ☐ No How much?_____

Other Party's Insurance Company:_____Claim #_____

Adjuster Name:_____Adjuster Phone #_____Email:_____

Did the police come to the accident site? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Were you wearing a seatbelt? ☐ Yes ☐ No

Was this vehicle equipped with airbags? ☐ Yes ☐ No

If yes , did it/they inflate? ☐ Yes ☐ No

In relation to the base of your skull, where was the headrest? ☐ Above ☐ Below ☐ At Base of Skull

What did your vehicle impact? ☐ Another Vehicle ☐ Other If other, explain: _____

Did any part of your body strike anything in the vehicle? ☐ Yes ☐ No If yes, explain: _____

Make and model of the other vehicle(s) involved: _____

Name of the location/street on which you were traveling: _____

What was the approximate speed of your vehicle? _____

Did the impact to your vehicle come from the: ☐ Front ☐ Rear ☐ Right Side ☐ Left Side ☐ Other

During impact, were you facing: ☐ Right ☐ Left ☐ Forward

Immediately at time of impact were you: ☐ Surprised ☐ Aware

If another vehicle was involved- approximate speed of the other vehicle: _____

In your own words, please describe the accident below:

Did the accident render you unconscious? ☐ Yes ☐ No If yes, for how long? _____

Please describe how you felt immediately after the accident: _____

Have you gone to a hospital or seen any other doctor? ☐ Yes ☐ No

If yes….

When did you go? ☐ Just After Accident ☐ Next Day ☐ 2+ Days Later

How did you get there? ☐ Ambulance ☐ Private transportation

Name of hospital and/or attending doctor: _____

Did you see a: ☐ D.C. (chiropractic) ☐ M.D. (medical)

Describe any treatment you received: _____

Were any X-Rays taken? ☐ Yes ☐ No

Was any medication prescribed? ☐ Yes ☐ No

Have you been able to work since this injury? ☐ Yes ☐ No

Are your work activities restricted as a result of this injury? ☐ Yes ☐ No

Indicate the symptoms that are a result of this accident:

☐ Dizziness	☐ Difficulty Sleeping	☐ Jaw Problems	☐ Nausea
☐ Memory Loss	☐ Irritability	☐ Arms/Shoulder Pain	☐ Back Pain
☐ Headache(s)	☐ Fatigue	☐ Numb Hands/Fingers	☐ Lower Back Pain
☐ Blurred Vision	☐ Tension	☐ Chest Pain	☐ Back Stiffness
☐ Buzzing in Ear	☐ Neck Pain	☐ Shortness of Breath	☐ Leg Pain
☐ Ears Ringing	☐ Neck Stiff	☐ Stomach Upset	☐ Numb Feet/Toes

☐Other: _____

Is your condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and Goes

Indicate your degree of discomfort while performing the following activities:

	Comfortable	Uncomfortable	Painful		Comfortable	Uncomfortable	Painful
Lying on Back	☐	☐	☐	Sports	☐	☐	☐
Lying on Side	☐	☐	☐	Working	☐	☐	☐
Lying on Stomach	☐	☐	☐	Lifting	☐	☐	☐
Sitting	☐	☐	☐	Bending	☐	☐	☐
Standing	☐	☐	☐	Kneeling	☐	☐	☐
Stretching	☐	☐	☐	Pulling	☐	☐	☐
Walking	☐	☐	☐	Reaching	☐	☐	☐
Running	☐	☐	☐				

Have you retained an attorney? ☐ Yes ☐ No

If yes, whom? _____

Attorney Phone Number: _____

Email (optional): _____

RECOVERY

How many hours are in your normal workday? _____

Please indicate on your daily job duties and any activities which you are occasionally asked to perform:

☐ Standing	☐ Driving	☐ Operating Equipment
☐ Sitting	☐ Twisting	☐ Work with Arms Above Head
☐ Walking	☐ Crawling	☐ Typing
☐ Lifting	☐ Bending	☐ Stooping

Other: _____

What positions can you work in with minimum physical effort and for how long?

_____ ☐ N/A

Prior to the injury were you capable of working on an equal basis with others your age? ☐ Yes ☐ No ☐ N/A

While in recovery, is there any light duty work you could request? ☐ Yes ☐ No ☐ N/A

We invite you to discuss any questions regarding our services with us. The best services are based on a friendly understanding between provider and patient.

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges, and other expenses incurred in collecting your account.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date _____

Signature of Guardian if Patient is a Minor _____ Date _____