Personal Injury/Auto Accident History

Name:_____ Age:____ Date of Birth:_____ Male Female

Address: _____ City/state: _____ Zip: _____

SS#: _____ Driver's License #: _____

Your Auto Insurance Company: _____ Phone #: _____

Name of Agent and/or Adjustor: _____ Claim #: _____

Do you have an Attorney? Y N Name: _____ Phone #: _____

3rd Party Auto Insurance Company: _____ Phone #: _____

Name of Agent and/or Adjustor: _____ Claim #: _____

Internal Office Use:
☐ Claim # verified

Adustor Name & Ph#:
Claims Mailing address:

GENERAL INFORMATION

Date of Accident: _____ Time of Accident: _____ City of Accident: _____

Did the police arrive? Yes No Please bring us a copy of the accident report.

State in detail how did the accident happened: _____

_____

_____

_____

_____

State any strange events that happened during or immediately after the accident:

_____

_____

_____

Have you had any time loss from work? Y N If yes, from _____ to _____

Were other people in the car? Y N

Were they injured? Y N If yes, please explain: _____

_____

Location in vehicle: Driver Passenger

If you were the passenger, where were you seated? _____

What type of vehicle were you in? Make/Model: _____ Year: _____

Your speed: stopped slowing accelerating cruising at _____ MPH

Time of Day: daylight dawn dusk dark Visibility: good fair poor

Road conditions: dry damp wet snowy icy

IMPACT

Was your car hit from the: front back left side right side

By what?: car truck SUV motorcycle other (vehicle or object): _____

Did your vehicle hit something? Y N If yes, what did you hit: _____

If you struck another object, did you strike it on the: front back left side right side

Did your vehicle go off the road? Y N

Damage to your vehicle: minimal moderate extensive unsure

Describe damage: _____

Do you have pictures of the automobile? Y N

DURING IMPACT

Wearing seatbelt? Y N Airbag Deployed? Y N

Headrest? Low Mid High Seatback position change? Y N

Brakes Applied? Y N Seat broken? Y N

Preparation for accident: Unexpected Expected Expected and body braced

Body Position: Straight Rotated left Rotated right Unsure Other: _____

Body thrown from seat? Y N How/to where? _____

Head position: Straight Rotated left Rotated right Unsure Other: _____

Head motion: Forward/Backwards Backwards/Forward Right to Left Left to Right

Did your body hit anything during impact? Y N Explain: _____

_____

AFTER ACCIDENT

How did you feel immediately after the accident?

Dizzy/Dazed Upset Weak Nervous Headache Disoriented Unconscious

Other: _____

Are you experiencing any pain? Y N Where? _____

_____

Are you experiencing any numbness? Y N Where? _____

MEDICAL CARE

Have you received any care since the accident? Y N

When? Next Day At the time of accident Later that day Days later _____

Transported? Y N Drove Self Ambulance Someone drove me

Went to: Ortho Chiropractor Neurologist Family Doctor ER Other: _____

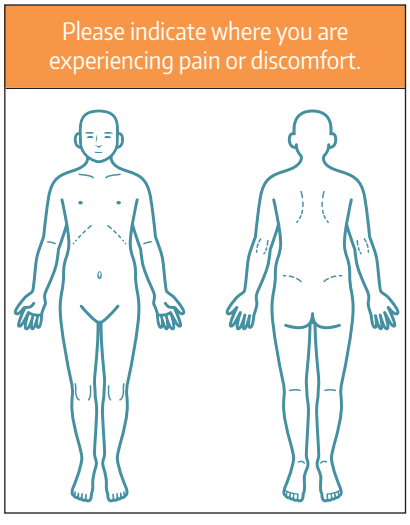
Admitted to Hospital: Y N Days spent: _____

Tests performed: X-ray Labs MRI CT Other: _____

Treatment received: _____

INJURY DETAIL

Please mark area(s) of injury:



ACKNOWLEDGEMENT & CONSENT

Patient Name: _____ Date: _____