AUTO ACCIDENT INFORMATION

Patient's Name ____________________ Date of Birth __________ Date ____________
Address ____ Date of Accident ____________
City __________________ State ________ Zip ________ Time of Accident ____________
Phone: (Home) ________________ (Cell) ________________ (Work) ____________
Referred by: ____________________ Place of Employment: ____________________
□ Single □ Married □ Separated □ Divorced □ Widowed

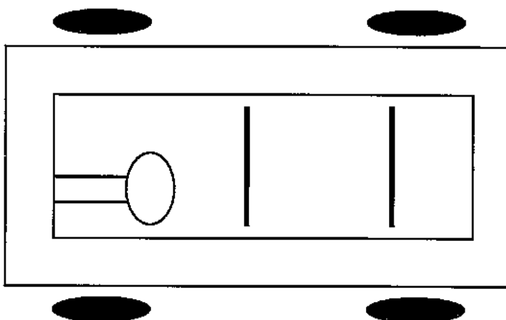
ACCIDENT DESCRIPTION

Just before the accident, my vehicle was:
□ at a traffic light □ at a stop sign □ going straight □ making a □right □left turn
□ entering traffic from a side street/driveway □ stopped for traffic ahead
□ traveling at _____m.p.h. □ other ____
Other vehicle: □ hit me in the rear □ ran a light □ making a □ right □ left turn
□ was entering traffic from a side street/driveway □ran across my lane
□other ____

- Fill in the box where your vehicle was hit.
- Place an 'X' inside the vehicle drawing to identify where you were sitting at the time of the accident.

My vehicle was hit:
Front Passenger Side Corner □ Passenger Side □ Rear Passenger Side Corner □

Front Bumper □



Rear Bumper □

Front Driver Side Corner □ Driver Side □ Rear Driver Side Corner □

□ I was the driver involved the: □ auto □ other accident.
Accident location: ______________________ City ______________ State ________
□ I was the passenger involved in the: □ auto □ other accident.
I was sitting in the: □ middle front seat □ right front seat □ left rear seat
□ middle rear seat □ right rear seat
Accident location: ______________________ City ______________ State ________
□ I was a pedestrian □ standing □ sitting □ riding a bike □ walking □ other
Vehicle Discription: Year _______ Make ______________ Model ______________
Transmission Type: □ Manual □ Automatic

Road conditions were: □ dry □ damp □ wet □ dark □ clear □ raining
Visability was: □ poor □ fair □ good
The road was made of: □ concrete □ asphalt □ gravel □ dirt □ other __________

Did your car have a head rest? □ Yes □ No
If your car had a head rest, what position was it in: □ up □ middle □ down
Were you: Wearing your seat belt: □ Yes □ No Wearing your harness: □Yes □No
Did your airbag deploy? □ Yes □ No □ No Airbag
Head position: At the time of the accident, my head was looking:
□ straight ahead □ to the right □ to the left □ up □ down □ other ___________
Brakes: Were your brakes applied at the time of impact? □ Yes □ No
Elbows: My left elbow was □ on the arm rest □ other _______________________
My right elbow was □ on the arm rest □ other_______________________
Hands: □ right □ left hand(s) □ on the steering wheel.
□ can't remember □ other ______________________________
Were you aware of the impending collision before it happened? □ Yes □ No
Did you tighten your body and brace for the collision? □ Yes □ No
Your hands, as a result of the impact:
□grabbed the steering wheel tightly □were forced off the steering wheel/stick shift
□ other ____
As a result of the impact, your body was thrown: □ forward □ backward
□right □left □turned to the right (clockwise) □turned to the left (counter-clockwise)
□ can't remember □ other ___________________________________
As a result of the impact, your head hit the: □ front windshield □ rearview mirror
□ steering wheel □ back of the seat in front of me □ driver's/passenger's inside window/door □ another person's body □ back of my head hit the headrest
□ other _______________________________ □ nothing
As a result of the impact, your shoulders were: □ impacted by the inside of the car door □ pressed firmly against the shoulder harness □ other________________
As a result of the collision, which other parts of your body struck the inside of the vehicle: □ ankles □ elbows □ face □ chest □ thighs □ forearms □ other
Did another car hit you? □ Yes □ No
Point of impact: □head-on □rear-end □left front □left rear □right front □right rear
Did your vehicle strike or impact with a second object after the first impact?
□ Yes □ No
Did your vehicle strike a: □car □truck □road/median □building □other _________
Were you wearing your glasses at the time of the accident? □Yes □ No □ N/A
If yes, were your glasses still on following the accident? □ Yes □ No
Did you lose consciousness as a result of the accident? □ Yes □ No
If yes, how long were you unconscious? ____

Vehicle Description: Make ________________ Model ___________________Year_______
Damage to my vehicle was: □ mild □ moderate □ severe
Damage to the other vehicle was: □ mild □ moderate □ severe
Estimated cost to repair your car: $_____________
After the accident, the car was: □ totaled □ drivable □ not drivable
At the time of the accident, how many people were in the car with you? ________
Names of occupants:

1. ______________________________ 3. ______________________________
2. ______________________________ 4. ______________________________

Were the other occupants injured? □ Yes □ No
If yes, describe injuries: ______________________________

____

Were the police called to the scene? □ Yes □ No
If yes, was an accident report written? □Yes □No
Was a ticket issued to you? □ Yes □ No
Was a ticket issued to the other driver: □Yes □ No

PATIENT INJURIES

As a result of the accident, I felt my symptoms:
□ immediately □ within one hour □within 6 hours □ during the night
□the next morning □ the next day □ other ______________
As a result of the accident, I felt:
□ headaches □upper back pain □chest pain/soreness □wrist/elbow pain/soreness
□ neck pain □low back pain □stomach pain/soreness □knee/ankle pain/soreness
□ shoulder pain □ numb/tingling/burning arms □ numb/tingling/burning legs
□ loss of bowel/bladder control □ other symptoms______________
Please list location of any cuts or bruises, if applicable: ______________

____

Did you go to the hospital? □ Yes □ No
If yes, when did you go? □immediately □next day □later that day □other______
Did you travel by: □ ambulance □ private transportation □ drove self
□ someone else drove
Name of hospital: ______________ City ______________
Were you admitted to the hospital? □ Yes □ No
If yes, how long was your stay: ______________
Hospital treatment: □ exams □ x-rays □ lab work
Follow-up recommendations: □ see your own doctor □ orthopedist/neurologist
□ physical therapist □ chiropractor □ braces/collars □ released from care
□ prescriptions:______________
If not, where did you go? □ home □ work □ your primary physician

Please list all doctors you have seen since the accident:

Doctor's Name	Date of Visit	Treatment	City	Released
1. ______	______	______	______	□Yes □No
2. ______	______	______	______	□Yes □No
3. ______	______	______	______	□Yes □No
4. ______	______	______	______	□Yes □No

Please list any special tests ordered by the hospital or physician(s):

____

____

____

WORK STATUS

Are you working now? ☐ Yes ☐ No
Were you employed at the time of this accident: ☐Yes ☐ No
Occupation: ____________________ Duties: ____
Are you currently working with restrictions? ☐ Yes ☐ No
If yes, please list work restrictions: ____

____

____

Has the doctor placed you on: ☐ total disability ☐ partial disability

Since the accident, do you feel: ☐worse ☐no improvement ☐better ☐other _______

If applicable, please rate level of improvement, with '10' being the very best:
Please circle: 1 2 3 4 5 6 7 8 9 10

Please rate level of pain, with '10' being the worst pain:
Please circle: 1 2 3 4 5 6 7 8 9 10

AUTO INS. COMPANY NAME: ____________________ PHONE: ________________
CLAIM NUMBER: ________________________ POLICY NUMBER ______________
PRIMARY INSURED NAME (if other than the patient): ________________________
RELATIONSHIP TO THE INSURED: ____
CLAIM ADJUSTER'S NAME: _____________________ PHONE EXT: ____________
ADDITIONAL ACCIDENT NOTES: ____

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MEDICAL HISTORY

Previous Injuries ____
Previous Back Pain ____
Illnesses ____
Operations ____
Medication(s) ____
Have you ever suffered from:

		☐ **Digestive Disorders**
☐ **Dizziness**	☐ **Arthritis**	☐ **Nervousness**
☐ **Backaches**	☐ **Headaches**	☐ **Sinus Trouble**
☐ **Heart Trouble**	☐ **Numbness**	☐ **Anemia**
☐ **Diabetes**	☐ **Asthma**	☐ **Rheumatic Fever**
☐ **Tuberculosis**	☐ **Neuritis**	☐ **Cancer**

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INFORMED CONSENT FOR TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, to include, but not limited to, various modes of physical therapy and diagnostic x-rays, on me (or the patient named below for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working, or associated with, serving as a back up for the chiropractor below.

I have had the opportunity to discuss with the doctor of chiropractic named below the nature and purpose of chiropractic adjustments and other procedures. I understand the results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts known, is in my best interest. Alternative treatment may include: medication, surgery, or physical therapy procedures. As with any procedure there are risks associated with these alternative procedures. If no treatment is sought your condition could get worse, remain the same, or improve.

I have read or have had read to me the above consent. I have had an opportunity to ask questions about its content and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and any future conditions for which I seek treatment.

To be completed by patient's representative, if patient is a minor or is physically or mentally incapacitated.

Patient's Signature Date	Name of Patient
Witness Signature Date	Signature of Patient's Representative
Preliminary Diagnosis	Relationship to Patient

ASSIGNMENT OF BENEFITS

I authorize the release of any medical or other information necessary to process my claims. I authorize payment of medical benefits to the undersigned physician for the medical services provided. The undersigned patient hereby assigns the rights and benefits of insurance under the applicable insurance policy for any services or charges. I acknowledge that insurance coverage is not a guarantee of payment. It is my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by my insurance company.

Patient's Signature	Date
Physician's Signature	Date