ADVANTAGE WALK-IN CHIROPRACTIC

NAME:_____ DATE:_____

ACCIDENT INFORMATION

DATE:_____ TIME:_____AM/PM

LOCATION OF ACCIDENT: (Street, City, State)_____

Did your vehicle strike another vehicle? Yes / No Did another vehicle strike your vehicle? Yes / No

If not, what did your vehicle impact?_____

PATIENTS CAR: (Make & Model) _____

Were you the: (Circle) *Driver* *Front Passenger* *Rear Passenger*

OPPOSING CAR: (Make & Model) _____

Was your vehicle equipped with airbags? *YES or NO* Did they inflate? *YES or NO*

Were you wearing a seatbelt? *YES or NO*

Were you aware of the approaching collision or did the impact take you by surprise?_____

Where did the impact come from?(Circle) *Front* *Rear* *Right side* *Left side* *Other:*_____

Patient's vehicle movement?(Circle) *Backing Up* *Stopped* *Forward* *Turning Left* *Turning Right*

If stopped, was your foot on the brake? *YES or NO*

Opposing vehicle's movement?(Circle) *Backing Up* *Stopped* *Forward* *Turning Left* *Turning Right*

Patient's vehicle speed?_____ Opposing vehicle's speed?_____

Which direction was the opposing vehicle headed?(Circle) *North* *South* *East* *West*

Which direction was the patient's vehicle headed?(Circle) *North* *South* *East* *West*

What was the estimated damage of the patient's vehicle?_____

Was the patient's vehicle towed from the scene?(Circle) *YES or NO*

What was the estimated damage of the opposing vehicle?_____

Was the opposing vehicle towed from the scene?(Circle) *YES or NO*

At the time of the collision, which direction were you facing? *looking right* *looking left* *looking forward*

In relation to the base of your skull, where was the headrest?_____

Did any part of your body strike anything in the vehicle?(Circle) *YES or NO* If yes, please list all parts of your body that made contact and with what part of the vehicle's interior.___

Did you receive a head injury due to the accident?(Circle) *YES or NO*

Did you lose consciousness (black out) upon impact? (Circle) *YES or NO*

Please describe in detail, to the best of your knowledge, what happened during this accident:

_____

_____

MEDICAL INFORMATION

Did EMS come to the accident scene?(Circle) *YES or NO*

Did you go to the hospital or see any other doctor?(Circle) *YES or NO*

If yes, name of hospital and/or attending doctor._____

Was he/she a:(Circle) *D.D.S. M.D. D.C. D.O.*

When did you go to the hospital?_____ How did you get to the hospital? _____

Was medication prescribed?(Circle) *YES or NO*

Were X-Rays / Imaging taken?(Circle) *YES or NO*

What treatment was given?_____

What was the diagnosis?_____

Have you been able to work since this injury?(Circle) *YES or NO*

If no, What dates were you unable to work? _____ to _____

Are your work activities restricted as a result of this injury? (Circle) *YES or NO*

Please describe how you felt immediately after the accident:_____

_____

If injuries were not immediately noticed, when did you start to notice your symptoms? _____

LEGAL INFORMATION

Did the police come to the accident scene?(Circle) *YES or NO*

Was a police report filed?(Circle) *YES or NO* ***(PLEASE ATTACH REPORT)***

Was a traffic violation issued?(Circle) *YES or NO* To whom?_____

PATIENT INFORMATION

PATIENT'S AUTO INSURANCE CO.:_____

POLICY #:_____ CLAIM #:_____

NAME OF YOUR INSURANCE ADJUSTER:_____

PHONE #:_____ FAX #:_____

INSURANCE ADDRESS:_____

Have you reported the accident to your insurance company? *YES / NO*

Is there Medpay / PIP coverage? *YES / NO*

HAVE YOU RETAINED AN ATTORNEY? (Circle) *YES or NO*

ATTORNEY NAME:_____ Phone #:_____

NAME OF THE LAW OFFICE: _____

Name the driver of the vehicle, if you were the passenger:_____

DRIVER'S INSURANCE CO.:_____

Policy #:_____ Claim #:_____

Insurance adjuster:_____ Phone#:_____

OPPOSING DRIVER INFORMATION

Opposing Driver's Name:_____

OPPOSING AUTO INSURANCE CO.:_____

POLICY #:_____ CLAIM #:_____

NAME OF YOUR INSURANCE ADJUSTER:_____

PHONE #:_____ FAX #:_____

INSURANCE ADDRESS:_____

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE and will update Advantage *Walk-In Chiropractic* if I become aware of any changes to the information stated above.

Signed:_____ Date:_____