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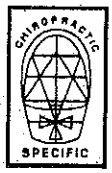

*Dr. Janice L. Noji, D.C.**
Doctor of Chiropractic

MOTOR VEHICLE ACCIDENT INFORMATION

NAME OF CLAIMANT: _____

DATE OF MOTOR VEHICLE ACCIDENT: _____

NAME OF INSURANCE COMPANY: _____

NAME OF ACCIDENT CLAIM ADJUSTER: _____

CLAIM# _____

ADJUSTER'S DIRECT PHONE NUMBER: _____

ADJUSTER'S DIRECT FAX LINE: _____

MOTOR VEHICLE ACCIDENT REPORT

NAME: _____ File #_____ Date: _____

When did the accident occur: Date: _____ Time: _____ A.M. P.M.

Where did the accident occur? Street or road: _____

Was this accident in any way related to your employment? [ ] yes [ ] no

Direction of travel:_____ Were you driving? [ ] Yes [ ] No

Number of Passengers: _____ Model of Vehicle: _____ Model of vehicle striking you:_____

Upon impact, was your car [ ] Stopped [ ] Moving [ ] Turning - [ ] Right or [ ] Left

State exactly where your car was struck: [ ] Side [ ] Front [ ] Rear

Estimated damage done to your vehicle: _____

Did you see the accident coming? [ ] Yes [ ] No Were seat belts worn? [ ] Yes [ ] No

Upon impact, which way were you thrown? _____

Upon impact was there a 'blinding' or 'explosion' sensation in your head? [ ] Yes [ ] No

State which areas of your body were hurt immediately after the accident: _____

_____

Were you able to get out of the car & walk? [ ]Yes [ ]No Were you conscious at all times? [ ]Yes [ ]No

Could you move all parts of your body? [ ]Yes [ ]No Was an ambulance called for you? [ ]Yes [ ]No

Did you go to the hospital? [ ]Yes [ ]No If so, what was done? _____

_____ [ ] x-rays? [ ] examination? [ ] medication?

Name of Hospital _____ Location _____

How long were you in the hospital? _____

Did you see any other doctor? [ ]Yes [ ]No If yes, name: _____

What discomfort did you have the next day? _____

_____

Was a police report made? [ ]Yes [ ]No Were charges laid? [ ]Yes [ ]No Against whom? _____

From the time of the accident, have you experienced any of the following symptoms?

Complaints of: [ ] Eyes [ ] Ears [ ] Face [ ] Dizziness [ ] Sweating [ ] Difficulty in Swallowing
[ ] Nasal Disturbances [ ] Chest Disturbances [ ] Unconsciousness [ ] Headaches
[ ] Insomnia [ ] Restlessness [ ] Mood Changes [ ] Symptoms in Arms or Legs
[ ] Numbness [ ] Tingling [ ] Difficulty in Moving [ ] Loss of Strength [ ] Inability to Void

Additional symptoms, not listed above: _____

_____