BalanceChiropractic

7165 E University Dr. Suite 102
Mesa, AZ 85207 480.830.0175

Automotive Accident Form

Billing Information

Patient name: _____ Time of injury:_____ □ AM □ PM
City and street where crash occurred: _____Date:_____
What is the estimated damage to your vehicle? $ _____
□ Yes □ No Do you have automobile medical insurance coverage? _____
_____
Name/address/phone _____
_____
What is yours car insurance medical coverage limit? $ _____
What is the claim number? _____
□ Yes □ No Do you know the claims adjuster's name? _____
□ Yes □ No Have you reported this injury to your car insurance company? _____
□ Yes □ No Did the police come to the accident scene and make a report? _____
□ Yes □ No Is an attorney representing you? Name/address/phone:_____
_____

Auto Accident Description

Describe how the crash happened _____
_____
_____
_____
_____
_____
_____

Collision Description
Check all that apply to you:

□ Single-car crash	□ Two-vehicle crash	□ More than three vehicles
□ Rear-end crash	□ Side crash	□ Rollover
□ Head-on crash	□ Hit guardrail/tree	□ Ran off road

You were the

□ Driver	□ Front Passenger	□ Rear passenger

Describe the vehicle you were in
Year, Make and Model: _____

□ Subcompact	□ Compact car	□ Mid-sized car
□ Full-sized car	□ Pickup truck	□ Larger than 1-ton

Patient Name: _____ Date of Birth: _____ Doctor Signature: _____

Describe the other vehicle

□ Subcompact car □ Compact car □ Mid-sized car
□ Full-sized car □ Pickup truck □ Larger than 1-ton

Estimated crash speeds

Estimate how fast your vehicle was moving at time of crash _____mph
Estimate how fast the other vehicle was moving at time of crash _____mph

At the time of impact your vehicle was

□ Slowing down □ Stopped □ Gaining speed □ Moving at steady speed

At the time of impact the other vehicle was

□ Slowing down □ Stopped □ Gaining speed □ Moving at steady speed

During and after the crash, your vehicle

□ Kept going straight, not hitting anything □ Spun around, not hitting anything
□ Kept going straight, hitting car in front □ Spun around, hitting car in front
□ Was hit by another vehicle □ Spun around, hitting object other than car

Describe yourself during the crash

Check only the areas that apply to you:

□ You were unaware of the impending collision
□ You were aware of the impending crash and braced yourself
□ Your body, torso, and head were facing straight ahead
□ You had your head turned and/or torso turned at the time of collision:
    □ Turned to left □ Turned to right
□ You were intoxicated (alcohol) at the time of crash
□ You were wearing a seat belt
    If yes, does your seat belt have a shoulder harness? □ Yes □ No
□ You were holding onto the steering wheel at the time of impact

Indicate if your body hit something or was hit by any of the following:

Please draw lines and match the left side to the right side.

Head	Windshield
Face	Steering wheel
Shoulder	Side door
Neck	Dashboard
Chest	Car Frame
Hip	Another occupant
Knee	Seat
Foot	Seat belt

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Check if any of the following vehicle parts broke, bent, or were damaged in your car

☐ Windshield	☐ Seat Frame	☐ Knee bolster
☐ Steering wheel	☐ Side/rear window	☐ Other_____
☐ Dashboard	☐ Mirror	☐ Other _____

Rear-end collisions only

Answer this section only if you were hit from the rear

Does your vehicle have?

☐ Movable head restraints
☐ Fixed, non-movable head restraints
☐ No head restraints

Please indicate how your head restraint was positioned at the time of crash

☐ At the top of the back of your head
☐ Midway height of the back of your head
☐ Lower height of the back of your head
☐ Located at the level of your neck
☐ Located at the level of your shoulder blades (upper back) below neck

*Estimate the distance between the back of your head and the front of the head restraints. _____ Inches

All types of collisions

Answer this section regardless of the type of crash, indicating those relevant to your case

Yes	No	
☐	☐	Did any of the front or side structures, such as the side door, dashboard, or floor board of your car, dent inward during the crash?
☐	☐	Did the side door touch your body during the crash?
☐	☐	Did your body slide under the seat belt?
☐	☐	Was a door of your vehicle damaged to the point it couldn't be opened?

Emergency department

Yes	No	
☐	☐	Did you go to the emergency department after the accident? What is name of the emergency department? _____ When did you go (date and time)? _____
☐	☐	Did you go the emergency department in an ambulance?
☐	☐	Did you or another person drive you the emergency department?
☐	☐	Were you hospitalized overnight?
☐	☐	Did the emergency department doctor take X-rays? Check what was taken: ☐ Skull ☐ Neck ☐ Low Back ☐ Arm or Leg

Patient Name: _____ Date of Birth: _____ Doctor Signature: _____

□ □ Did the emergency department doctor give you pain medications?
□ □ Did the emergency department doctor give you muscle relaxants?
□ □ Did you have any cuts or lacerations?
□ □ Did you require any stitches for cuts?
□ □ Were you given a neck collar or back brace to wear?

When did you first notice any pain after injury?
□ Immediately □ ___Hours after injury □ ____Days after injury

If you did not see a doctor for the first time within the first week, indicate why
Check all that apply
□ No pain was noticed □ No appointment schedule available le
□ No transportation □ Work/home schedule conflicts

If you did not see a doctor for the first time within the first month, indicate why
Check all that apply
□ No pain was noticed □ No appointment schedule available
□ No transportation □ Work/home schedule conflicts
□ I thought pain would go away □ I had no insurance or money
□ I self-treated with over-the-counter drugs □ I took hot showers, used ice, heat

Have you been unable to work since injury?
□ Yes □ No If yes, you were off work □ partially or □ completely
Please list date off work: _____ to _____.