Elk Valley Family Chiropractic

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Client's Accident Report

Client's Name:_____Claim #_____
Attorney's Name:_____ Insurance Adjuster's Name_____
1) When did the accident occur? Date:_____ Time:_____
Where did the accident occur? Street:_____ Direction:_____
2) Were you driving? Yes No
Number of passengers? _____
Model of vehicle in the accident_____
Upon impact was the vehicle: Stopped?_____ Moving?_____ Turning (L or R)? _____
State exactly where the vehicle was struck: Side?_____ Rear?_____ Front?_____
Model of vehicle striking you?_____
Estimated damage to vehicles?_____
3) Did you see the accident coming? Yes No
Were you wearing a seatbelt? Yes No
Upon impact which way were you thrown? _____
Upon impact was there a "*Blinding*" or *Explosion*" sensation in your head? Yes No
Which areas of your body were hurt immediately after the accident? _____
Were you able to get out of the car and walk? Yes No
Were you conscious at all times? Yes No
Could you move all parts of your body? Yes No
4) 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_____
How long were you in hospital? _____ Name of hospital? _____
Did you see another doctor? Yes No Name of Doctor?_____

5) What discomfort did you have the first evening? _____
Were you able to sleep that first night? Yes No
What discomfort did you have the next day? _____

6) Was a Police report made?_____ Were charges laid? _____ Against whom?_____

7) From the time of the accident have you experienced any of the following symptoms:
Discomfort of the: Eyes Ears Face
Dizziness Sweating Difficulty in swallowing Nasal Disturbances Chest disturbances
Unconsciousness Headaches Insomnia Restlessness Moodiness
In your arms and legs, did you experience any: (please state whether arms or legs)
Numbness_____ Tingling_____ Difficulty moving_____
Lost of strength _____ Inability to Void _____
8) Other comments:

_____
_____

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