

Auto Accident Form

Patient Information

Today's Date _____ Date of Collision _____

First Name _____ Phone 1 _____ Marital Status _____
Last Name _____ mobile home work single married other

DOB _____ Phone 2 _____ Working Status _____
Sex male female mobile home work employed
SSN _____ Email _____ full-time student
Address _____ Employer _____ part-time student
City _____ Employer Phone _____
State _____ Occupation _____
Zip Code _____

Auto Insurance

Primary Insurance

Insurance Name _____
Insurance Phone _____
ID# _____ Group # _____
Insured: First Name _____
Last Name _____
SSN _____ DOB _____
Copay _____ Deductible _____ Co-Ins _____

Relationship to Insured self spouse child other

Secondary Insurance

Insurance Name _____
Insurance Phone _____
ID # _____ Group # _____
Insured: First Name _____
Last Name _____
SSN _____ DOB _____
Copay _____ Deductible _____ Co-Ins _____

Relationship to Insured self spouse child other

Accident History

When did the accident occur? _____ days ago _____ weeks ago _____ years ago other _____

Where were you located at the time of the accident? driver front passenger rear passenger pedestrian

If you were not the driver type the name, address and telephone number of the driver

How many passengers were in the accident vehicle? _____

Have you retained an attorney? yes no

Attorney Information

Attorney Name _____
Attorney Address _____
Attorney Phone _____

Driver of Other Vehicle Information

Other Driver Name _____
Other Driver Address _____
Other Driver Phone _____

Did anyone witness the accident? no one person two people three people several people

If yes, name, address and details of the witness or witnesses

Where did the accident occur? at an intersection in a parking lot in town on the interstate on a highway
 other _____

What is the make and model of your vehicle? _____

How many vehicles were involved in the accident? _____

What direction were you headed? north east south west

How fast was the vehicle going at time of impact? _____ mph

At impact, was the vehicle stopped, slowing down or speeding up? stopped slowing down speeding up

Was the other vehicle stopped, slowing down or speeding up? stopped slowing down speeding up

What time of day did the accident occur? morning afternoon evening night

How were the driving conditions at the time of the accident? normal dry icy stormy wet windy

What type of impact occurred? side-driver's side-passenger's front rear

Did the vehicle hit another structure after the accident? did not building ditch fire hydrant median
 pole railing second vehicle tree other _____

Was your vehicle struck by another vehicle? yes no

Did any part of your body strike anything in the vehicle? face jaw neck shoulders elbows
 chest hips legs shins knees feet other _____

Where were you looking at the time of impact? straight ahead to the left to the right up down

Which hands were on the steering wheel? none both hands left hand right hand

Which foot was on the brake? both neither left foot right foot

Which position was the headrest in? vehicle did not have a headrest low in mid-position high

What air bags deployed? no air bags deployed steering wheel air bag driver's side air bag passenger's side air bag

Were you wearing a seatbelt? yes no

What doors would not open as a result of the accident? all doors freely opened after accident front left front right
 rear left rear right other _____

What other treatment have you received for the accident?

Did you go to hospital? yes no

Hospital Information

Hospital Name _____ Hospital Location _____

Were you hospitalized overnight? yes no

Were you prescribed anything? arm brace crutches knee brace leg brace muscle relaxers
 neck brace pain medication topical analgesic wrist brace other _____

What services were performed at the hospital? none evaluation by a medical doctor X-rays MRI CT scan
 cast emergency life saving procedures blood transfusion stitches other _____

- What types of diagnostic tests have been performed?** amniocentesis basic metabolic panel biopsy CAT scan
 celiac profile colonoscopy complete blood count complete blood count with differential
 comprehensive metabolic panel diagnostic ultrasound echocardiogram electrolyte panel endoscopy
 extended cardiac risk profile hepatic function panel hepatitis panel, acute hepatitis panel, chronic
 lipid panel mammogram MRI OB profile PET scan renal panel urinalysis X-ray or X-ray series

Condition

- What treatments have you received since the accident?** ice heat oral pain medication topical analgesics
 muscle relaxers wrist brace knee brace neck brace ankle brace crutches other _____

- How often have you been receiving treatment?** daily twice per week three times per week
 four times per week five times per week weekly bi-weekly monthly

Details of treatment received

Location and provider where previous treatment was received

- Are you responding to treatment?** the same improving worse other _____

- How did you feel immediately following the accident?** head pain neck pain neck stiffness jaw/facial pain (TMJ)
 shoulder pain shoulder stiffness arm pain chest pain back pain low back pain lower limb pain
 back stiffness ear buzzing/ringing in the ears feet/toe numbness or tingling hands/fingers numbness or tingling
 upper limb numbness or tingling cold feet cold hands cold sweats constipation anxiety
 depression diarrhea difficulty swallowing dizzy/dazed disoriented fainting fatigue
 forgetfulness impaired concentration irritability sensitivity to light sensitivity to noise loss of balance
 loss of smell loss of taste loss of memory muscle spasms nauseous nervousness pins and needles
 restlessness shortness of breath sleeping problems stomach upset tension vision blurred weakness

- What symptoms did you experience since the accident?** head pain neck pain neck stiffness
 jaw/facial pain (TMJ) shoulder pain shoulder stiffness arm pain chest pain back pain low back pain
 lower limb pain back stiffness ear buzzing/ringing in the ears feet/toe numbness or tingling
 hands/fingers numbness or tingling upper limb numbness or tingling cold feet cold hands cold sweats
 constipation anxiety depression diarrhea difficulty swallowing dizzy/dazed disoriented
 fainting fatigue forgetfulness impaired concentration irritability sensitivity to light
 sensitivity to noise loss of balance loss of smell loss of taste loss of memory muscle spasms
 nauseous nervousness pins and needles restlessness shortness of breath sleeping problems
 stomach upset tension vision blurred weakness

- Describe the pain?** aching burning cramping deep dull numb radiating sharp
 shooting stabbing stiff swelling tight tingling throbbing

- Does the pain travel anywhere else?** denies radiating pain TMJ left TMJ right TMJ cranium (headache)
- left cranium (headache) right cranium (headache) cervical left upper cervical right upper cervical
- left lower cervical right lower cervical upper thoracic left upper thoracic right upper thoracic
- mid thoracic left mid thoracic right mid thoracic lower thoracic left lower thoracic right lower thoracic
- anterior rib left anterior rib right anterior rib posterior rib left posterior rib right posterior rib
- upper lumbar left upper lumbar right upper lumbar lower lumbar left lower lumbar right lower lumbar
- lumbosacral right lumbosacral left lumbosacral right sacroiliac left sacroiliac left anterior shoulder
- right anterior shoulder left posterior shoulder right posterior shoulder right arm left arm right elbow
- left elbow right forearm left forearm right wrist left wrist right hand left hand right hip
- left hip right leg left leg right thigh left thigh right knee left knee right calf
- left calf right ankle left ankle right foot left foot

Rate your pain on a scale of 0 to 10. *0 being no pain at all and 10 being the worst pain imagineable*

- 0 1 2 3 4 5 6 7 8 9 10

How many days of work have you missed as a result of this accident? _____

Have you received X-rays for this accident? yes no

If yes, by whom?

- If yes, which areas were X-rayed?** skull (head) cervical (neck) thoracic (mid back) ribs lumbar (low back)
- sacral/pelvis chest abdomen left shoulder right shoulder left elbow right elbow
- left wrist right wrist left hand right hand left hip right hip left upper leg right upper leg
- left knee right knee left lower leg right lower leg left ankle right ankle left foot right foot

Certification and Assignment

I certify that I, and/or my dependent(s) have insurance coverage with _____
 And assign directly to the above named Chiropractic clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Payment policy

The above named Chiropractic clinic may use my healthcare information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below. I understand regardless of my insurance status, I am ultimately responsible for any charges for professional services rendered by the above named Chiropractic clinic.

 Signature of Patient, Parent, Guardian or Personal Representative

Date _____

 Print Name of Patient, Parent, Guardian or Personal Representative

Date _____