Northwest Family
CHIROPRACTIC & MASSAGE

Motor Vehicle Accident Related Complaint

Patient Name: _____ Date:_____

Date of injury: _____ Time of accident: _____am/pm In WA state? Y or N:_____state

Did you open a Personal Injury Protection (PIP) claim through your own auto insurance? Yes / No / Unsure

Your Auto Insurance Company: _____

Claim Manager Name: _____ Claim Manager phone #:_____
Claim #:_____ *Policy Limit:_____

**We strongly recommend you obtain your PIP policy limit information and relay this to our billing department, so that we can better help you track your service costs in office. We are unable to obtain this information on your behalf.*

Do you have an attorney?: Yes / No

If yes, Name:_____ Phone #:_____

In your own words, please describe the accident:

_____

_____

Were you the:	□ driver	□ passenger		
Where were you in the car:	□ front	□ back	□ drivers side	□ passenger side
Was your vehicle hit from:	□ front	□behind	□side	
How many impacts were there:	□ one	□ two	□ three	□ other:_____
Was the headrest positioned:	□ at the level of the head		□ below the head	□ above the head
Were you wearing your seatbelt?	□ yes	□ no		
Did the air bags deploy?	□ yes	□ no		
Did you black out?	□ yes	□ no	□ I don't know	
Did you have your head turned?	□ yes	□ no	□ I don't know	
Did police come to the scene?	□ yes	□ no		
Was a citation written?	□ yes	□ no	If yes, to whom? _____	
Did an ambulance come to the scene?	□ yes	□ no		
Were you transferred to the hospital?	□ yes	□ no	If yes, which one? _____	
Have you seen any other provider?	□ yes	□ no		

If yes, please list:

Name:_____ Phone # _____

Name: _____ Phone # _____

Please list any other treatment/care you have had for this injury:

_____

_____