

# 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 \_\_\_\_\_