Columbia City Chiropractic

AUTOMOBILE ACCIDENT FORM

Your Name:_____ Today's Date:_____

Date of Accident:_____ Time of Accident:_____

City of Accident:_____ Street of Accident:_____

Road conditions at time of accident: (circle one) WET DRY ICY OTHER_____

Did the police come to the scene of the accident? (circle one) YES NO

How many people were in the car at the time of the accident, including yourself? _____

Did you go to a hospital (circle one) YES NO

If yes, what was the name and city of the hospital?_____

How did you get there?_____

What parts of your body were x-rayed at the hospital?_____

What did the hospital do for your injuries?_____

How long did you stay at the hospital?_____

What bleeding cuts did you sustain during this accident?_____

What bruises did you sustain during this accident?_____

Where were you seated in the vehicle?_____

Were you aware of the approaching impact or were you caught by surprise? (circle one)

AWARE SURPRISE

Did you lose consciousness (black out) upon impact? (circle one) YES NO

If so, for how long?_____

Did you experience a flash of light or explosion in your head? (circle one) YES NO

Immediately after the accident did you become (circle all that apply)

CONFUSED DISORIENTED LIGHT-HEADED BLURRED VISION NAUSEATED

DIZZY RING/BUZZ IN EARS

Which, if any, of the above symptoms do you still have?_____

Are you currently suffering from any of the following (circle all that apply)

RESTLESSNESS IRRITABILITY DIFFICULTY CONCENTRATING

FORGETFULNESS REDUCED ALCOHOL TOLERANCE SLEEPLESSNESS

REDUCED TOLERANCE FROM HEAT

How far is the top of the headrest or seatback from the top of your head (approximately)?

_____inches (circle one) ABOVE BELOW

Were you wearing a seatbelt? (circle one) YES NO

If yes, was it a lap seatbelt_____ or a shoulder-lap seatbelt_____

Did you receive any bruises from the seatbelt (circle one) YES NO

If yes, then describe:_____

List the year, make, and model of the vehicle you were in:

year_____ make_____ model_____

Was your car stopped at the time of the impact? (circle one) YES NO

If no, estimate the speed of the vehicle you were in _____mph

Was your vehicle (circle one) SPEEDING UP SLOWING DOWN STEADY SPEED

Specify where each of the following body parts came in contact with the vehicle during impact

head hit_____ chest hit_____

right/left shoulder hit_____right/left arm hit_____

right/left hip hit_____ right/left leg hit_____

right/left knee hit_____ other_____

What is the estimated cost of damage to the vehicle you were in?_____

Which of the following car parts were damaged during the accident? (circle all that apply)

WINDSHIELD FRONT SEAT BACK RIGHT/LEFT SIDE WINDOW

STEERING WHEEL OTHER_____ OTHER_____

What is the year, make, and model of the other vehicle?

year_____ make_____ model_____

Was the other vehicle moving at the time of the collision? (circle one) YES NO

If yes, what was its approximate speed? _____mph

Was the other vehicle (circle one) GAINING SPEED SLOWING DOWN STEADY RATE

Please describe, to the best of your knowledge, what happened during this accident:

_____

_____

_____

_____

_____

Patient's Auto Insurance company:_____ Policy # _____

Claims #_____ Adjuster's Name_____ Phone_____

Claims Address_____

Patient's Attorney's name_____ phone_____

Attorney's address_____

Other driver's Insurance company_____ Policy #_____

Adjuster's name_____ Phone_____

Claims Address_____