THE CHIROPRACTIC
wellnessconnection

Auto Accident Information

Patient Name: _____
Date:_____

Date and time of accident:_____ AM____ PM____
Were you the: Driver_____ Front Passenger_____ Rear Passenger_____
Make and model of the vehicle you were occupying?_____
If a traffic violation was issued, to whom it issued?_____
Number of people in accident vehicle?_____
Did the police come to the accident site? Yes_____ No_____
Was a police report filed? Yes_____ No_____
Were there any witness? Yes_____ No_____
Were you wearing a seat belt? Yes_____ No_____
Was this vehicle equipped with airbags? Yes_____ No_____
If yes, did it/ they inflate? Yes_____ No_____
In relation to the base of your skull, where was the headset?
Above____ Below____ At base of skull____
What did your vehicle impact? Another vehicle_____ Other____
If other, explain:_____
Did any part of your body strike anything in the vehicle? Yes_____ No_____
If yes, please describe:_____
Make and model of the other vehicle(s) involved? _____
Name of the location/street on which you were traveling? _____
In which direction were you headed? N___ S___ E___ W___
What was the approx. speed of your vehicle? _____
Did the impact to your vehicle come from the:
Front____ Rear____ R-Side____ L-Side____ Other____
During the impact, were you facing: Right____ Left____ Forward____
Were you _____ aware or _____ surprised by the impact?
If in the accident the vehicle made impact with another vehicle…
Direction other vehicle was headed? N___ S___ E___ W___
Approximate speed of the other vehicle? _____
In your own words, please describe the accident:
_____
_____
_____
_____
_____

Indicate your degree of comfort while performing the following activities:

Lying on back……. _____Comfortable _____Uncomfortable _____Painful
Lying on side……. _____Comfortable _____Uncomfortable _____Painful
Lying on stomach... _____Comfortable _____Uncomfortable _____Painful
Sitting……... _____Comfortable _____Uncomfortable _____Painful
Standing…….. _____Comfortable _____Uncomfortable _____Painful
Stretching……. _____Comfortable _____Uncomfortable _____Painful
Lovemaking…… _____Comfortable _____Uncomfortable _____Painful
Walking……... _____Comfortable _____Uncomfortable _____Painful
Running…….. _____Comfortable _____Uncomfortable _____Painful
Sports……. _____Comfortable _____Uncomfortable _____Painful
Working…….. _____Comfortable _____Uncomfortable _____Painful
Lifting…….. _____Comfortable _____Uncomfortable _____Painful
Bending…….. _____Comfortable _____Uncomfortable _____Painful
Kneeling……. _____Comfortable _____Uncomfortable _____Painful
Pulling……. _____Comfortable _____Uncomfortable _____Painful
Reaching……. _____Comfortable _____Uncomfortable _____Painful

Have you retained an attorney: ____Yes ____ No
If yes, whom? _____
His/Her phone #: _____

Recovery

How many hours are in your normal workday? _____

Please indicate on your daily job duties and any activities, which are occasionally asked to perform.

____ Standing
____ Sitting
____ Walking
____ Lifting
____ Driving
____ Twisting
____ Crawling
____ Bending
____ Operating equipment
____ Work with arms above head
____ Lifting

____ Other _____

What positions can work in with minimum physical effort and for how long?
_____ N/A_____

Prior to the injury were you capable of working on an equal basis with others your age?
____ Yes ____ No ____ N/A

Do you work with others who can help you with any heavy lifting?
____ Yes ____ No ____ N/A

While in recovery, is there any light duty work you could request?
____ Yes ____ No ____ N/A

- We invite you to discuss with us any questions regarding our services. The best services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Your auto insurance company's name (even if another party is at fault):_____Claim #_____

Name of auto insurance company of the party that hit you:
_____Claim #_____

Signature_____ Date ____/____/____
____ Adult Patient ____ Parent or Guardian ____ Spouse