

LAKE STEVENS CHIROPRACTIC CLINIC
MOTOR VEHICLE ACCIDENT/COLLISION INFORMATION

PATIENT INFORMATION

Name: First _____ Initial _____ Last _____ Today's Date: _____

Date of Accident: _____ Time of Accident: _____

Please describe the accident/collision in your own words: _____

Were you the: Driver Front Passenger Rear Passenger Pedestrian How many people were in your vehicle? _____

INSURANCE INFORMATION

Your Insurance Company (PIP): _____

PIP Claim Number: _____

PIP Adjuster's Name: _____

Adjuster's Phone Number: _____

Date PIP Application was filled out: _____

If not filled out, why?: _____

Amount of PIP Available: _____

Responsible Party Insurance (3rd Party): _____

3rd Party Claim Number: _____

Responsible Party Name: _____

Do you have an Attorney? Yes No

Attorney Name: _____

Attorney Address: _____

Attorney Phone Number: _____

POLICE

Did the police come to the accident site? Yes No

Were there any witnesses? Yes No

Was a police report filed? Yes No

Was a traffic violation issued? Yes No

If yes, to whom? _____

ACCIDENT/COLLISION SITE

Road/Street Name: _____

City/State _____

Nearest Intersection with road/street: _____

Driving Conditions: Dry Wet Icy Other _____

Which direction were you headed? _____

Speed you were traveling: _____

VEHICLE

Make and Model of vehicle you were in: _____

Were you wearing a seatbelt? Yes No

If Yes, what type? Lap Shoulder

Was the vehicle equipped with airbags? Yes No

If yes, did they inflate properly? Yes No

Did your seat have a headrest? Yes No

If yes, what was the position of the headrest?

Low Midposition High

OTHER VEHICLE

Make and Model of other vehicle: _____

Which direction was other vehicle traveling? _____

Speed other vehicle was traveling: _____

Name of other driver: _____

IMPACT

Did your vehicle impact another vehicle? Yes No

Did your vehicle impact a structure? Yes No

If yes, please explain: _____

Did any part of your body strike anything in the vehicle?

Yes No If yes, explain: _____

Was impact from: Front Rear Left Right

Other _____

At time of impact were you looking:

Straight ahead Left Right Down Up

Were both hands on the steering wheel? Yes No

If no, which hand was on the wheel? Left Right

Was your foot on the brake? Yes No

If yes, which foot was on the brake? Left Right

PATIENT CONDITION

Were you: Surprised by impact Braced for impact

Were you unconscious immediately after the accident?

Yes No If yes, for how long? _____

Please describe how you felt immediately after the

accident/collision: _____

Did you go to the hospital? Yes No

When did you go? Immediately after the accident

Next day 2 or more days after the accident

How did you get to the hospital?

Ambulance Private transportation

Name of Hospital: _____

TREATMENT

Name of doctor: _____ Clinic Name: _____

Diagnosis: _____ Treatment received: _____

X-rays taken: _____

Other health care professionals seen for this injury: _____

SYMPTOMS/INJURIES

Have you been able to work since this injury? Yes No How many work days have you missed? _____

Prior to the injury were you able to work on an equal basis with others your age? Yes No

Please check appropriate boxes if you have had any of the following symptoms since your injury:

Neck pain Ear buzzing Headaches Arm/shoulder pain Nausea

Neck stiffness Ear ringing Irritability Chest/rib pain Stomach upset

Back Pain Fatigue Jaw problems Shortness of breath Blurred vision

Back stiffness Feet/toe numbness Leg/hip pain Sleep difficulty Memory loss

Dizziness Hand/finger numbness Knee pain Facial pain/numbness Tension

Is the condition getting progressively worse? Yes No Unknown

How often do you have this pain? _____ Is it constant or does it come and go? _____

Does it interfere with your: Work Sleep Daily routine Recreation

Activities or movements that are painful to perform: Sitting Standing Walking Bending Laying down

I certify that this information is correct to the best of my knowledge, and I authorize above listed insurance companies to release privileged information regarding my claim to Lake Stevens Chiropractic Clinic as indicated.

Patient Signature: _____

Date: _____

