CAR ACCIDENT / PERSONAL INJURY INFORMATION

PUYALLUP CHIROPRACTIC / CLINIC

PAIN RELIEF WITH A GENTLE TOUCH

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Patient Name:_____ Today's Date:_____

Address:_____

City:_____ State:_____ Zip: _____

INSURANCE INFORMATION OF THE VEHICLE YOU WERE IN AT THE TIME OF INJURY

Patient's Auto Insurance Co.: _____ Policy:_____

Claim#:_____ Claims Address:_____

City:_____ State:_____ Zip:_____

Adjuster's Name:_____ Adjuster's Phone:_____

Name of Attorney:_____Attorney Phone:_____

Attorney's Address:_____

City:_____State:_____Zip:_____

OTHER DRIVERS INFORMATION

Driver Of Other Vehicle:_____

Address If Known:_____

City:_____ State: _____ Zip: _____

Insurance Co.:_____ Policy: _____

Claims Address:_____ Claim #:_____

City:_____ State: _____ Zip: _____

Adjuster's Name:_____ Adjuster's Phone:_____

OVER

ACCIDENT DETAILS

1. Date of Accident: _____ Time of Day:_____ Road Conditions:_____
2. Were You: ☐ Driver ☐ Passenger ☐ Front Seat ☐ Back Seat ☐ Left Side ☐ Right Side
3. Number of people in your vehicle:_____ Other vehicle:_____
4. City, State & County where accident occurred:_____
5. What direction were you headed: ☐ North ☐ South ☐ East ☐ West
6. What direction was the other vehicle headed: ☐ North ☐ South ☐ East ☐ West
7. From what direction were you struck: ☐ Behind ☐ Front ☐ Left Side ☐ Right Side
8. Did you experience an altered state of consciousness? (dizziness / dazed / confused / loss of memeory) ☐ Yes ☐ No
   If yes, for how long?_____
9. Were police notified? ☐ Yes ☐ No (Please give front desk a copy of the accident report).
10. Describe the accident:

11. Did you have any physical complaints before the accident? ☐ Yes ☐ No

12. What are your present complaints which you attribute to the accident?

13. Have you ever been involved in an accident before? ☐ Yes ☐ No If yes, describe the accident, including date, as well as injuries received:

14. Were you taken to the hospital for this present accident? ☐ Yes ☐ No
    Name & Address of Hospital:_____
15. Have you been treated by another doctor since the accident? ☐ Yes ☐ No If yes, please provide info:
    Name & Address of Doctor: _____
    What type of treatment did you receive?_____
16. Since the accident, are your symptoms: ☐ Getting Worse ☐ Improving ☐ About the Same
17. Have you lost time from work as a result of this accident? ☐ Yes ☐ No
    If yes, give the last Date worked:_____Type of Employment: _____
    Present Salary: _____ Comments: _____
18. What activity restrictions do you notice as a result of this accident?

19. Other pertinent information or comments:

Signature of Patient: _____ Date: _____