

Eastside Spine & Wellness
Motor Vehicle Accident History

Patient Name: _____ Date: _____ Phone: _____

Do you have PIP (Personal Injury Protection) under your automobile policy? Yes No

Name of your Insurance Co.: _____ Agent's Name: _____

Agent's Phone #: _____ Policy #: _____ Claim #: _____

Name of other vehicle driver: _____

Other driver's Insurance Co.: _____ Agent's Name: _____

Agent's Phone #: _____ Policy #: _____ Claim #: _____

Any witnesses? Yes No If yes, please give names: _____

ACCIDENT/INJURY HISTORY

1. Date of Accident: _____ Time of Day: _____ AM/PM Road Condition: Dry Wet
2. Were you: Driver Passenger Front Seat Back Seat
3. Number of people in your vehicle? _____ Other Vehicle? _____
4. Were you wearing your seat belt? Yes No If No, go to question #6.
5. If yes, were you wearing a lap belt? Yes No Lap belt and shoulder harness? Yes No
6. What direction were you headed? North South East West
On (name of street and city): _____
7. What direction was the other vehicle headed? North South East West
On (name of street and city): _____
8. Were you struck from? Behind Front Left Side Right Side
Other combination, please describe: _____
9. What was the position of your head just before the accident? Straight Ahead Turned Right
 Turned Left Other: _____
10. Did any part of your body strike/hit anything inside of your vehicle (steering wheel, dashboard, window, etc.)?
 Yes No Please explain: _____
11. Did any items become displaced in the vehicle (seat back, rearview mirror, packages, etc.)? Yes No
Please explain: _____
12. Approximate speed of your car? _____ mph Estimated speed of the other vehicle? _____ mph
13. Make & model of your car: _____ Make & model of other vehicle: _____
14. Were the police notified? Yes No
Was a citation issued? Yes No If yes, to whom? _____
15. In your own words, please describe the accident: _____

16. Did you have any physical complaints BEFORE the accident? Yes No
If yes, please describe in detail: _____

17. Please describe how you felt: _____

- A. DURING the accident: _____
- B. IMMEDIATELY AFTER the accident: _____
- C. LATER THAT DAY: _____
- D. The NEXT DAY: _____
18. Were you knocked unconscious? Yes No If yes, for how long? _____
 Were you: Aware Surprised by the impact? Did the airbags inflate? Yes No
 In relation to the base of your skull, where was the head rest? Above Below At base of skull
19. Where were you taken after the accident? _____
20. Have you been treated by another doctor since this accident? Yes No
 If yes, please list Dr.'s name and address: _____
 What type of treatment did you receive? _____
21. Since this injury occurred, are your symptoms: Improving Getting Worse Staying the Same
22. Have you ever been involved in an accident before? Yes No
 If yes, when? _____
 Describe the accident(s): _____

23. Did this accident occur while you were performing your regular job duties? Yes No
24. Have you lost time from work as a result of this accident? Yes No
 Type of employment: _____
 Last Date worked: _____
25. Do you have a previous illness/disease which affects your present condition? Yes No
 If yes, please describe: _____

Please add anything else you would like the doctor to know: _____

AUTHORIZATION

I certify that I have read and I understand the above information to the best of my knowledge. The questions above have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize this office to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such chiropractic care to the third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to this office benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient's Signature: _____ Date: _____
 (Signature of parent if the patient is a minor)

Doctor's Comments:

