AUTOMOBILE ACCIDENT HISTORY

We require the following information to process your auto accident claim. If you do not have this information, please obtain it or we cannot treat you.
If you have an attorney, we will work with your attorney directlyto obtain this information. If you do not have an attorney or MedPay, payment is due at time of service.

Patient name

Your Name:_____ **Driver of the vehicle you were in:**_____

Name of YOUR / THEIR auto insurance company:_____

Policy # _____ **Claim #** _____

Auto Insurance Phone # _____ **Name of Adjuster**_____

Amount of YOUR Medpay Coverage _____ **Claim # if different than above**_____

Your Attorney_____ **Attorney Phone #**_____

Driver of the other (AT FAULT) vehicle_____

Name of their auto insurance company:_____

Policy # _____ **Claim #** _____

Auto Insurance Phone # _____ **Name of Adjuster**_____

1. Date of accident _____ **2. Time of accident** _____ **AM / PM** ◯ Day ◯ Dawn ◯ Dusk ◯ Dark

3. Road conditions at time of of accident: ◯ Wet ◯ Dry ◯ Snow ◯ Ice ◯ Other _____

4. Was the accident on the job? ◯ YES ◯ NO

5. Were you in a company vehicle? ◯ YES ◯ NO

6. Where were you seated in the vehicle? ◯ Driver ◯ Passenger front seat ◯ Passenger rear seat ◯ Other _____

7. Where you aware of the approaching impact, or did it catch you by surprise? ◯ Aware ◯ Surprised

8. Did you lose consciousness on impact? ◯ YES ◯ NO

9. Did you experience a flash of light or explosion in your head? ◯ YES ◯ NO

10. Did the police come to the accident scene? ◯ YES ◯ NO

11. Is there a police report? ◯ YES ◯ NO

12. Did you go to the hospital? ◯ YES ◯ NO **13. When?** ◯ Immediately ◯ ____ Hours Later ◯ ____ Days Later

14. What hospital? _____ **How long did you stay in the hospital?** _____

15. What did the hospital do for your injuries? (Collar / Splint / X-rays / Medication Etc.) ? _____

_____

16. What areas were X-rayed / MRI / CT Scan? _____

17. What was diagnosis? _____

18. What did they recommend for follow up care? _____

19. Was any other doctor consulted after the accident? ◯ YES ◯ NO **If yes, who?** _____

Specialty? _____ **Date Seen?** _____ **Type Treatment?** _____
How long did you treat? _____ **Treatment Frequency?** _____

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_____

Consultation Notes

Doctor's Initials
Dr. Kellie C. Baxter BS, DC

AUTOMOBILE ACCIDENT HISTORY

Patient name

20. Were you wearing a seat belt? ◯ YES ◯ NO **If yes, did you receive any injury or bruise from the seat belt?** ◯ YES ◯ NO

21. Did your head hit the headrest? ◯ YES ◯ NO **If adjustable was the headrest position altered?** ◯ YES ◯ NO

22. Was the seat adjustment altered by the accident? ◯ YES ◯ NO **Was the seat broken by the accident?** ◯ YES ◯ NO

23. Did the air bag deploy? ◯ YES ◯ NO **If yes, did it strike you?** ◯ YES ◯ NO **Where?** _____

24. Which way was your headed pointed at impact? ◯ Straight ◯ Right ◯ Left **Which way was Body pointed?** ◯ Straight ◯ Right ◯ Left

25. Were your hands on the wheel? ◯ One on wheel ◯ Both on wheel ◯ Not applicable

26. List the year, make and model of *YOUR* car: YEAR_____ **MAKE** _____ **MODEL**_____

27. Was your car stopped at the time of impact? ◯ YES ◯ NO **If yes, was the drivers foot on the brake?** ◯ YES ◯ NO

28. If you were not stopped estimate the speed of the vehicle you were in _____**MPH.**

29. If your vehicle was moving at the time of impact was it : ◯ Slowing down ◯ Gaining speed ◯ Steady speed

OTHER CAR

30. List the year, make, and model of *OTHER* other car: YEAR_____ **MAKE** _____ **MODEL** _____

31. Was the other car moving at the time of impact? ◯ YES ◯ NO

32. What was the approximate speed of the other vehicle _____**MPH.**

33. Was the other vehicle at the time of impact : ◯ Slowing down ◯ Gaining speed ◯ Steady speed

34. Please describe to the best of your knowledge, what happened during the accident: _____

_____

_____

_____

_____

_____

_____

Consultation Notes

35. At the time of the accident did you become or experience any of the following: ◯ Confused ◯ Disoriented ◯ Light headed
◯ Dizzy ◯ Ringing / buzzing in ears ◯ Nauseated ◯ Blurred vision ◯ Loss of balance ◯ Other _____

36. Do you stiill have any of those symptoms? ◯ YES ◯ NO **If yes, which ones?** _____

37. Please check off all symptoms you have had since the accident:

◯ Headache	◯ Tension	◯ Paralysis	◯ Neck Pain	◯ Joint Pain / Stiffness	◯ Weakness
◯ Migraine	◯ Nervousness	◯ Pinched Nerve	◯ Mid Back Pain	◯ Urinary Problems	◯ Vertigo
◯ Dizziness	◯ Loss of Sleep	◯ Fatigue	◯ Low Back Pain	◯ Pins & Needles	◯ Spasms
◯ Jaw Pain / Click	◯ Loss of Balance	◯ Irritability	◯ Sciatica	◯ Tingling	◯ Other
◯ Loss of Smell	◯ Vision Problems	◯ Depression	◯ Shoulder Pain	◯ Numbness	_____
◯ Difficulty Swallowing	◯ Sinus Pain	◯ Anxiety	◯ Arm / Leg pain	◯ Sore Muscles	_____
◯ Buzzing in Ears	◯ Fainting	◯ Light Bothers	◯ Chest Pain	◯ Stomach Upset	_____
◯ Loss of Memory	◯ Fever	◯ Cold Hands / Feet	◯ Digestive Problems	◯ Head Feels Heavy	

37. Does your job involve: ◯ Sitting ◯ Standing **How long?** _____ ◯ Lifting **How much?** _____ ◯ Bending ◯ Twisting / Turning

38. Physical activity at work: ◯ Sedentary ◯ Light Manual Labor ◯ Manual Labor ◯ Heavy Manual Labor

39. Have you missed work due to the accident? ◯ YES ◯ NO **If yes, how many days?** _____

40. Are your work activities restricted as a result of the accident? ◯ YES ◯ NO **If yes, explain** _____

_____

41. Do any of your work activities aggravate your present complaints? ◯ YES ◯ NO **If yes, explain** _____

_____

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