AUTOMOBILE ACCIDENT HISTORY

MARR CHIROPRACTIC

Name: _____ Age: _____ Date of Birth: _____ M F

Address: _____

SS#: _____ DL#: _____

Insurance Company: _____ Phone # : _____

Name and Phone of *Local Insurance Agent*: _____

Address of Local Insurance Company: _____

Has this accident been reported to your insurance company? YES NO

CLAIM NUMBER _____

CLAIM REPRESENTATIVE AND PHONE NUMBER _____

CLAIM BILLING ADDRESS _____

Is your auto insurance PRIMARY SECONDARY If secondary, please provide Primary insurance information to staff

Primary Insurance Info _____

_____

Is there a deductible? YES NO If yes, how much? _____

Have you retained an attorney? YES NO

If yes, Name & Telephone of Attorney: _____

Complete Address for Attorney: _____

GENERAL SYMPTOMS

Did you hit any part of your body during the collision, for example: head on dash, chest on steering wheel? YES NO

If yes, which part and how? _____

_____

Where were you taken after the accident? _____

Were you hospitalized? YES NO If Yes, for how long and where? _____

Did you receive care from any other health care specialist? YES NO

If yes, what is the specialist's name? _____

What type of care were you given, and for how long? _____

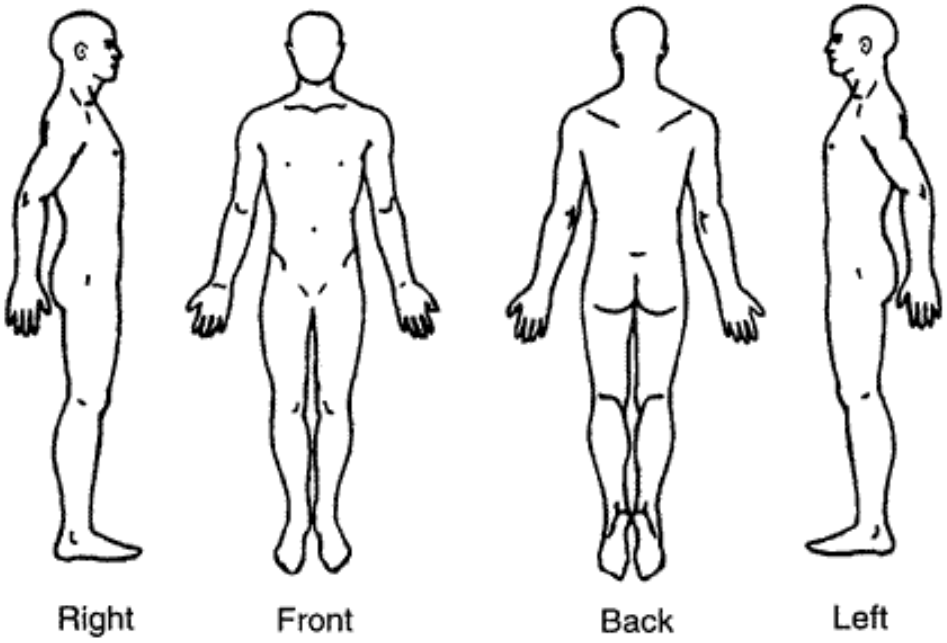
Where did you feel the pain? _____

What are your current symptoms? _____

Have you ever been injured in a similar manner? YES NO

If yes, how and when? _____

Mark Pain Area



ACCIDENT HISTORY

Date of accident: _____ Time of Accident: _____ AM PM

State how the accident happened in your own words: _____

_____

_____

What type of vehicle were you in? Make/ Model _____ Year: _____

Were you driving? YES NO Was it your car? YES NO

If not, whose car was it? _____

Passenger? FRONT BACK RIGHT SIDE LEFT SIDE

Were you rotated in the seat? YES NO Were you reclined? YES NO

In relation to the base of your skull, where was the headrest? ABOVE BELOW AT BASE OF SKULL

Were there other people in the car? YES NO

If yes, explain: _____

Were seat belts on? YES NO Position of headrest? _____

Was it? DAYLIGHT NIGHT DUSK DAWN

What were the weather conditions? _____

Were you tired? YES NO Were you awake? YES NO

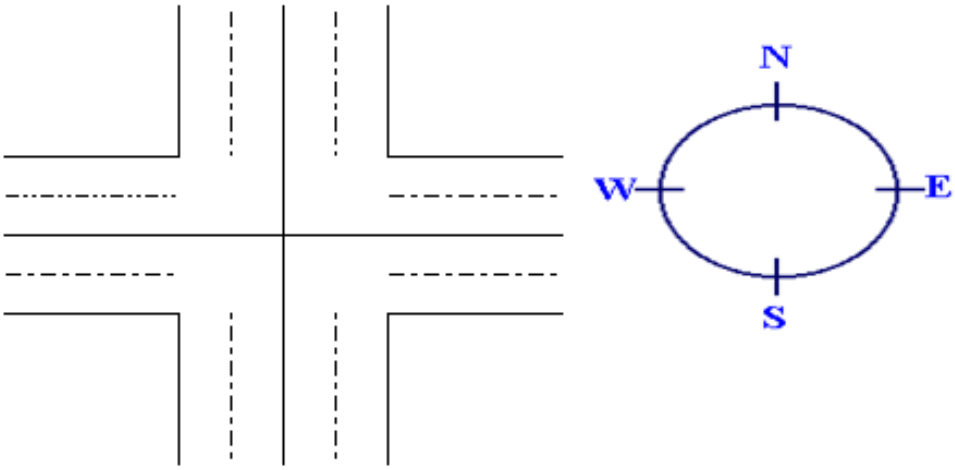
How long had you been in the car? _____

Where were you prior to the accident? _____

What were the traffic conditions? _____

What was the posted speed limit? _____ How fast were you going? _____

Please draw the accident



Type of road: 2 LANE 4 LANE GRAVEL ASPHALT

Did it happen at a/an: STOP SIGN TRAFFIC LIGHT INTERSECTION HIGHWAY

Was your car hit? FRONT BACK LEFT SIDE RIGHT SIDE

In which direction were you headed? NORTH SOUTH EAST WEST

What damage was done to your car?

Inside _____

Outside _____

Other _____

If you struck another car, did you strike it: FRONT BACK SIDE What was the damage to the other car?

Inside: _____

Outside: _____

In what condition was the vehicle prior to the accident? _____

Do you have pictures of the involved automobile? YES NO

What size and type of vehicle was involved in the accident? _____

Was an accident report made? YES NO

Police of: City - _____ County - _____ State _____

Who was ticketed? _____ For what? _____

Did your vehicle strike anything? YES NO If yes, was it ANOTHER CAR SIGN TREE BRIDGE HEDGE EMBANKMENT

OTHER/describe - _____

Did your vehicle go off the road? YES NO

If yes, IN A DITCH AN EMBANKMENT How deep/describe _____

Does it bother you to ride in a car now? YES NO If yes, as a DRIVER PASSENGER

State any strange events that happened during or immediately after the accident: _____

_____.

Were you completely conscious after the impact? YES NO If no, how long were you unconscious? _____

Do you remember the impact? YES NO

Describe how you felt immediately after the accident: _____

_____.

Have you gone to a hospital? YES NO If yes, what hospital? _____

Have you seen any other Doctor? YES NO If yes, who did you see and when? _____

Phone and address of other DR. _____

When did you go? JUST AFTER ACCIDENT NEXT DAY 2 DAYS PLUS

How did you get there? AMBULANCE PRIVATE TRANSPORTATION

Have you had any time loss from work? YES NO If yes, from _____ to _____

Are your work activities restricted as a result of this injury? YES NO

Have you had to have any outside help? YES NO If yes, what type? _____

Check the symptoms that are a result of this accident:

☐ Dizziness	☐ Memory loss	☐ Headache(s)	☐ Blurred vision	☐ Buzzing in ear
☐ Ears ringing	☐ Difficulty Sleeping	☐ Irritability	☐ Fatigue	☐ Tension
☐ Neck pain	☐ Neck stiff	☐ Jaw problems	☐ Arms/ shoulder pain	
☐ Numb hands/fingers		☐ Chest pain	☐ Shortness of breath	☐ Stomach upset
☐ Nausea	☐ Back pain	☐ Lower back pain	☐ Back stiffness	☐ Leg pain
☐ Numb feet/ toes		Other : _____		

Patient Signature; _____ Date: _____

Staff Signature; _____ Date: _____