MARKET PLACE CHIROPRACTIC WELLNESS CENTER
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:_____

YOUR 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 Market Place Chiropractic Wellness Center as indicated.

Patient Signature:_____ **Date:**_____