

MILL CREEK CHIROPRACTIC CLINIC, P.S. / Ryan Doerge, D.C.

AUTOMOBILE ACCIDENT HISTORY FORM

Name: _____ Date: _____

Date of Accident: _____ Time of the Accident: _____(am/pm)

City of Accident: _____ Street of Accident: _____

Road condition at the time of accident: Wet Dry Icy other: _____

Were you: Driver Passenger(front seat/backseat) Pedestrian

How many occupants in your vehicle? _____

Were you struck from: Behind Front Right Left Parked

Did your car strike the other(s) involved? Yes No

Did the other car(s) strike yours? Yes No

Were you aware of the approaching collision prior to impact, or did the impact catch you by surprise? Aware Unaware

Did you lose consciousness(black out) on impact? Yes No

If yes, how long _____

How far is the top of the headrest or seatback from the top of your head _____

inches. Is this above or below the top of your head? Above Below

Were you wearing a seatbelt? Yes No Lap belt or shoulder/lap

Did you feel any popping, tearing, ripping or hear any noise in your neck or back?

Yes No If yes, what? _____

Were you stunned or disoriented? How long? _____

On what part of the automobile did the following body parts hit?

Head: _____ Face: _____ Chest: _____

Right/Left Shoulder: _____

Right/Left Arm: _____

Right/Left Hip: _____

Right/Left Leg: _____

Right/Left Knee: _____

Other: _____

Was the trunk of your body facing straight-forward at time of impact? Yes No

If No, what direction was it turned and by how much? _____

Was your head facing straight-forward? Yes No

If No, what direction was it turned and by how much? _____

Did you find any bruises? Yes No Where? _____

Did you find any bleeding cuts? Yes No Where? _____

Did the police come to the accident scene? Yes No

Were traffic citations issued?

To you? Yes No

To the driver of your car? Yes No

To the driver of the other car? Yes No

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VEHICLE INFORMATION

List the year, make, and model of the vehicle you were in.

Year _____ Make _____ Model _____

Was your car stopped at the time of impact? Yes No

If yes was the driver foot also on the brake? Yes No

If moving, what was the speed of your vehicle? _____ MPH

Where you slowing down, gaining speed, or traveling at a steady rate of speed at the time of impact? _____

Patient headed (N S EW)

What's the cost damage to the vehicle you were in? _____

If moving, what was the speed of the other vehicle? _____ MPH

Was it slowing down, gaining speed, or traveling at a steady rate of speed at the time of impact?

Which of the following car parts (if any) were broken during the accident?

- a) Windshield b) Front Seatback c) Steering wheel
- d) Right/Left side window e) Other

Have you been contacted by an insurance adjuster or company representative regarding this claim? Yes No

Do you have an attorney that had advised you in this case? Yes No

Attorneys Name: _____

Address: _____

Phone: _____

Please describe the accident in your own words:

(Include place of accident, road conditions and any special circumstances.)

INSURANCE INFORMATION

Have you reported this accident to your car insurance carrier? _____

The PIP insurance from the automobile you were in (or yours if the car was not insured) is responsible to pay for your medical care, not the insurance of the person who caused the accident. The PIP insurance that pays your care will be reimbursed by the other insurance company at time of settlement. Your personal automobile insurance rates cannot be raised for filing a PIP claim as Washington state law prohibits this if someone else is at fault.

The Cars PIP company: _____
Address: _____
Phone: _____
Claim#: _____
Policy holders name: _____
Adjusters name: _____

Patients Insurance company: _____
Address: _____
Phone: _____
Claim#: _____
Adjusters name: _____
Policy holders name: _____

Patient's personal health ins. carrier: _____
Policy holders name: _____

Company(s) of other person(s) involved in the Accident
Name of Company: _____
Address: _____
Phone: _____
Claim#: _____
Adjusters Name: _____
Driver's name: _____
Policy holders name: _____