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

WERE YOU TAKEN TO THE HOSPITAL? Yes No If yes answer the following:

What was the name of the hospital? _____________ In what city ___________________

How did you get to the hospital ? ____

Were you examined ? ____

What parts of your body were X-rayed ?____

Any treatment given ? Yes No Medication?______________________________

Cervical Collar? Yes No

Any recommendations given?____

____

CHECK SYMPTOMS YOU HAD BEFORE AND AFTER THE ACCIDENT

B	A		B	A	
		Headache	o	o	Dizziness
		Neck pain	o	o	Head seems too heavy
		Neck stiff	o	o	Pain in arm(s)
		Sleeping problems	o	o	Pain in leg(s)
		Back pain	o	o	Numbness in finger(s)
		Nervousness	o	o	Numbness in toe(s)
		Tension/Pain	o	o	Shortness of breath
		Pain between the shoulders	o	o	Chest tight
		Irritability	o	o	Fatigue
		Chest pain	o	o	Depression/Upset
		Light bothers eyes	o	o	Loss of memory
		Diarrhea	o	o	Cold feet
		Ears ring	o	o	Cold hands
		Face flushed	o	o	Stomach upset
		Buzzing in ears	o	o	Constipation
		Loss of balance	o	o	Cold sweats
		Fainting	o	o	Loss of smell
		Loss of Taste	o	o	Fever
o		_______________	o		_____________________________________

Any symptoms other than above? ____

Have you lost any days of work? Yes No What dates? ________________________

What are your symptoms now? ____

Were you treated before for any of these symptoms? _______________________________

Any previous accidents, hospitalizations, fractures?

Year ? ____

Year ? ____

Year ? ____

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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.)

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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:____