Automobile Accident Information Form

ASPEN RIDGE CHIROPRACTIC

Name: _____ Today's Date: _____

Date of Accident: _____ Time of Accident: _____ am/pm

Location of Accident _____

Did you go to the hospital? ☐ NO ☐YES (If yes, answer questions below)

Name of the hospital? _____

How did you get to the hospital? _____

What parts of your body were x-rayed at the hospital? _____

What did the hospital do for your injuries? _____

How long did you stay at the hospital? _____

What bleeding or cuts did you sustain during this accident? _____

What bruises did you sustain during this accident? _____

Where were you seated in the vehicle?

☐Driver ☐Front Passenger ☐Left Rear ☐Middle Rear ☐Right Rear

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

☐Aware ☐Surprised

Did you lose consciousness (black out) upon impact? ☐ NO ☐YES How long: _____

Did you experience a flash of light or explosion in your head ☐ NO ☐YES

How far is the top of the headrest or seat back from the top of your head (approximately):_____ inches above or below?

Were you wearing a seat belt? ☐ NO ☐ YES (Lap Seatbelt or Shoulder/Lap Seatbelt)

Did you receive any injury or bruise from the seat belt? ☐ NO ☐YES (If yes, please describe)

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

Head Hit_____ Chest hit _____

Right/ left shoulder hit _____ Right/left arm hit _____

Right/left hip hit_____ Right/left leg hit _____

Right/left knee hit _____ Other _____

Did you become one of the following from the accident?

☐ Confused ☐ Nauseated ☐Disoriented ☐ Blurred Vision

☐ Dizzy ☐ Lightheaded ☐ Ring/Buzz in Ears

If you still have any of those symptoms, which ones are still occurring? _____

Are you currently suffering from any of the following?

☐ Difficulty Concentrating ☐ Restlessness ☐ Sleeplessness ☐ Chills

☐ Reduced Tolerance to Heat ☐ Difficulty with Memory ☐ Forgetfulness ☐ Irritable

☐ Reduced Tolerance to Alcohol

Was the trunk of your body pointed straight forward at the time of the collision?

☐ NO ☐YES

If no, how was it turned? _____

Was you head pointed straight forward? ☐ NO ☐YES

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

Which of the following car parts broke during the accident?

☐ Windshield ☐ Steering Wheel ☐ Right/Left Side Window

☐ Front/Back Seat ☐ Other _____

Did the police come to the accident scene? ☐ NO ☐YES

Is there a police report? ☐NO (if no, please completed the following questions)

☐YES (if yes, please attach a copy of the police report)

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

Year _____Make _____Model _____

Road conditions at the time of accident: ☐ Wet ☐ Dry ☐ Snow/Icy ☐ Other

Was your car stopped at the time of impact? ☐ NO ☐YES

If yes, was your/the driver's foot also on the brake? ☐ NO ☐YES

If no, then estimate the speed of the vehicle you were in _____ mph

If the other vehicle was moving at the time of the collision, was it:

☐ Slowing Down ☐ Gaining Speed ☐ Traveling at a steady speed

If your vehicle was moving at the time of impact, was it:

☐ Slowing Down ☐ Gaining Speed ☐ Traveling at a steady speed

What is the estimated cost of damage to the vehicle you were in? $ _____

Your Insurance Company / Insurance of vehicle in which you were injured (if applicable)

Auto Insurance Name _____

Auto Policy Number _____ Accident Claim Number _____

What is the year, make and model of the other vehicle?

Year _____ Make _____ Model _____

Insurance of the driver of other vehicle (if any)

Auto Insurance Name _____

Auto Policy Number _____ Accident Claim Number _____

Name of insurance adjustor: _____

Contact information (phone and/or email): _____

Have you retained an attorney? ☐Yes ☐No

Name and contact information of the attorney:

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

_____

_____

_____

_____

_____

_____

_____