Biss Clinic of Chiropractic

Auto Accident Form

Name: ______________________________ Phone: (   ) __________

Address:______________________ City: ______________ State:_____ Zip:________

Age: ________ Birthdate: ______________ Sex: __________ SSN: ________ - ________ - ________

Employer's Name: ________________________ Employer's Address: ________________________

Your Ins. Co.: ______________ Policy #: ______________ Agent's Name: ______________

Name on Policy (if other than self): ________________________ Policy #: ______________

Responsible Party's Name: ____

Address:______________________ City: ______________ State:_____ Zip:________

Policy Holder's Name ________________________ Policy #: ______________

ATTORNEY

Name: ______________________________ Phone: (   ) __________

Address:______________________ City: ______________ State:_____ Zip:________

Were there any witnesses? ☐ Yes ☐ No Name(s): ________________________________

____

Nature of Accident

1. Date of Accident: ________________ Time of Day: ________________
2. Were you: ☐ Driver ☐ Passenger ☐ Front Seat ☐ Back Seat
3. Number of people in your vehicle? ________ Were you wearing seat belts? ________________
4. What direction were you heading? ☐ North ☐ East ☐ South ☐ West

   On (name of street): ____
5. What direction was the other vehicle heading? ☐ North ☐ East ☐ South ☐ West

   On (name of street): ____
6. Were you struck from: ☐ Behind ☐ Front ☐ Left Side ☐ Right Side
7. Approximate speed of you car: ________ mph Other car: ________ mph
8. Were you knocked unconscious? ☐ Yes ☐ No If yes, for how long? ________________
9. Were police notified? ☐ Yes ☐ No

Nature of Accident (cont.)

10. In your own words, please describe the accident: ______________________________

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11. Did you have any physical complaints BEFORE THE ACCIDENT? ☐ Yes ☐ No If so, please describe in detail:

____

____

____

12. Please describe how you felt:
    a. DURING the accident: ______________________________
    b. IMMEDIATELY AFTER the accident: ______________________________
    c. LATER THAT DAY: ______________________________
    d. THE NEXT DAY: ______________________________
13. What are your PRESENT complaints and symptoms? ______________________________

____

____

14. Do you have any congenital (from birth) factors which relate to this problem? ☐ Yes ☐ No If yes, please describe:

____

15. Do you have any previous illnesses which relate to this case? ☐ Yes ☐ No If yes, please describe:

____

16. Have you ever been involved in an accident before? ☐ Yes ☐ No If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received: ______________________________

____

____

17. Where were you taken after the accident: ______________________________
18. Have you been treated by another doctor since the accident? ☐ Yes ☐ No If yes, please list doctor's name and address: ______________________________

    What type of treatment did you receive? ______________________________

____

19. Since this injury occurred, are your symptoms: ☐ Improving ☐ Getting Worse ☐ Same

Nature of Accident (cont.)

20. CHECK THE SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

☐ Headaches	☐ Neck Pain	☐ Back Pain	☐ Chest Pain	☐ Dizziness
☐ Tension	☐ Stiff Neck	☐ Sleeping Problems	☐ Nervousness	☐ Fatigue
☐ Loss of Memory	☐ Upset Stomach	☐ Numbness in Toes	☐ Feet Cold	☐ Fainting
☐ Ears Ring	☐ Irritability	☐ Numbness in Fingers	☐ Hands Cold	☐ Constipation
☐ Buzzing in Ears	☐ Depression	☐ Pins/Needles in Arms	☐ Cold Sweats	☐ Fever
☐ Lights Bother Eyes	☐ Loss of Balance	☐ Pins/Needles in Legs	☐ Loss of Smell	☐ Diarrhea
☐ Shortness of Breath	☐ Face Flushed	☐ Head Seems Heavy	☐ Loss of Taste	☐ ____________

Symptoms Other Than Above: ____

21. Have you lost time from work as a result of this accident? ☐ Yes ☐ No If yes, please complete the following:
   a. Last Day Worked: ____
   b. Type of Employment: ____
   c. Present Salary: ____
   d. Are you being compensated for time lost from work? ☐ Yes ☐ No If yes, please state the type of compensation you are receiving: ____

22. Do you notice any activity restrictions as a result of this injury? ☐ Yes ☐ No If yes, please describe in detail:

____
____
____
____
____

23. Other pertinent information: ____

____
____
____
____

Patient's Signature: ______________________________ Date: ____________________