Horsley
CHIROPRACTIC & PHYSICAL REHABILITATION

AUTO ACCIDENT FORM

INSURANCE INFORMATION

NAME: TODAYS DATE: / /

YOUR INSURANCE CARRIER: POLICY NUMBER:

CLAIM NUMBER: EFFECTIVE DATE:

PHONE NUMBER: ADDRESS:

ADJUSTERS NAME: DATE OF ACCIDENT: / /

CLAIM OPEN: YES / NO ARE YOU REPRESENTED BY AN ATTORNEY: YES / NO

IF YES, BY WHOM?

YOUR INVOLVEMENT IN THE ACCIDENT: ☐PEDESTRIAN ☐DRIVER ☐PASSENGER **WAS IT CONSIDERED YOUR FAULT?** YES / NO / UNDETERMINED

PATIENT WAS LOCATED: ☐ DRIVER ☐ PASS MIDDLE FRONT ☐ PASS RIGHT FRONT ☐ PASS LEFT REAR ☐ PASS MIDDLE REAR ☐ PASS RIGHT REAR

PATIENT VEHICLE TYPE: ☐ COMPACT ☐ MID-SIZE ☐ FULL SIZE ☐ SUV ☐ PICK-UP ☐ MOTORCYCLE

SECOND VEHICLE TYPE: ☐ COMPACT ☐ MID-SIZE ☐ FULL SIZE ☐ SUV ☐ PICK-UP ☐ MOTORCYCLE

ROAD CONDITIONS: ☐ CLEAR ☐ DARK ☐ DRY ☐ FOGGY ☐ ICY ☐ WET
ROAD TYPE: ☐ ASPHALT ☐ CONCRETE ☐ DIRT ☐ GRAVEL

WERE YOU AWARE THE ACCIDENT WAS GOING TO OCCUR? YES / NO **WERE YOU WEARING A SEATBELT?** YES / NO **DID AIRBAG DEPLOY?** YES / NO

DOES YOUR VEHICLE HAVE A HEAD REST? YES / NO **WHAT POSITION WAS THE HEAD REST IN?** ☐ UP ☐ MIDDLE ☐ DOWN

PATIENT'S HEAD POSITION: ☐ LOOKING STRAIGHT AHEAD ☐ LEFT LEVEL ☐ LEFT UP ☐ LEFT DOWN ☐ RIGHT LEVEL ☐ RIGHT UP ☐ RIGHT DOWN ☐ LOOKING UP ☐ LOOKING DOWN

WAS YOUR CAR BRAKING? YES / NO **WAS YOUR CAR MOVING?** YES / NO **IF YES, HOW FAST? (MPH)** ☐ <5 ☐ 6-10 ☐ 11-15 ☐ 16-20 ☐ 21-30 ☐ 31-40 ☐ 41-50 ☐ 51-60 ☐ 60+

WAS THE 2ND CAR BRAKING? YES / NO **WAS 2ND CAR MOVING?** YES / NO **IF YES, HOW FAST? (MPH)** ☐ <5 ☐ 6-10 ☐ 11-15 ☐ 16-20 ☐ 21-30 ☐ 31-40 ☐ 41-50 ☐ 51-60 ☐ 60+

COLLISION DETAILS: **FIRST IMPACT:** ☐ HIT BY OTHER VEHICLE ☐ HIT OTHER VEHICLE ☐ HIT BY OBJECT ☐ HIT OBJECT
IMPACT LOCATION: ☐ FRONT ☐ FRONT-RIGHT ☐ FRONT-LEFT ☐ LEFT ☐ RIGHT ☐ RIGHT-REAR ☐ LEFT-REAR ☐ REAR ☐ TOP

SECOND IMPACT: ☐ HIT BY OTHER VEHICLE ☐ HIT OTHER VEHICLE ☐ HIT BY OBJECT ☐ HIT OBJECT
IMPACT LOCATION: ☐ FRONT ☐ FRONT-RIGHT ☐ FRONT-LEFT ☐ LEFT ☐ RIGHT ☐ RIGHT-REAR ☐ LEFT-REAR ☐ REAR ☐ TOP

BRIEFLY DESCRIBE WHAT HAPPENED: ______________________________

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COLLISION RESULTS:
HEAD HIT ANYTHING? OTHER(CHEST, SHOULDER, KNEES)?

VEHICLE DAMAGE:
PATIENT VEHICLE: ☐ TOTALED ☐ SIGNIFICANT DAMAGE ☐ LIGHT DAMAGE ☐ NO DAMAGE
SECOND VEHICLE: ☐ TOTALED ☐ SIGNIFICANT DAMAGE ☐ LIGHT DAMAGE ☐ NO DAMAGE

HOSPITALIZED: **WERE YOU HOSPITALIZED?** YES / NO IF YES, PLEASE ANSWER QUESTIONS BELOW
WHEN WERE YOU HOSPITALIZED? ☐ IMMEDIATELY ☐ LATER SAME DAY ☐ NEXT DAY DATE:______________
HOW WERE YOU TRANSPORTED TO THE HOSPITAL? ☐ AMBULANCE ☐ LIFE FLIGHT ☐ PRIVATE TRANSPORTATION
WHAT DID THE HOSPITAL RECOMMEND? ☐ SEE OWN DOCTOR ☐ SEE SPECIALIST ☐ PRESCRIBE MEDICATION______________

DID YOU HAVE X-RAY'S TAKEN? YES / NO IF YES, WHAT AREAS______________________________