

**MARKET PLACE CHIROPRACTIC WELLNESS CENTER**  
**MOTOR VEHICLE ACCIDENT/COLLISION INFORMATION**

**PATIENT INFORMATION**

Name: First \_\_\_\_\_ Initial \_\_\_\_\_ Last \_\_\_\_\_

Today's Date: \_\_\_\_\_

Date of Accident: \_\_\_\_\_

Time of Accident: \_\_\_\_\_

Please describe the accident/collision in your own words: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Were you the:  Driver  Front Passenger  Rear Passenger  Pedestrian How many people were in your vehicle? \_\_\_\_\_

**INSURANCE INFORMATION**

**ACCIDENT/COLLISION SITE**

Your Insurance Company (PIP): \_\_\_\_\_

Road/Street Name: \_\_\_\_\_

PIP Claim Number: \_\_\_\_\_

City/State \_\_\_\_\_

PIP Adjuster's Name: \_\_\_\_\_

Nearest Intersection with road/street: \_\_\_\_\_

Adjuster's Phone Number: \_\_\_\_\_

Driving Conditions:  Dry  Wet  Icy  Other \_\_\_\_\_

Date PIP Application was filled out: \_\_\_\_\_

Which direction were you headed? \_\_\_\_\_

If not filled out, why?: \_\_\_\_\_

Speed you were traveling: \_\_\_\_\_

Amount of PIP Available: \_\_\_\_\_

**YOUR VEHICLE**

Responsible Party Insurance (3<sup>rd</sup> Party): \_\_\_\_\_

Make and Model of vehicle you were in: \_\_\_\_\_

3<sup>rd</sup> Party Claim Number: \_\_\_\_\_

Responsible Party Name: \_\_\_\_\_

Were you wearing a seatbelt?  Yes  No

Do you have an Attorney?  Yes  No

If Yes, what type?  Lap  Shoulder

Attorney Name: \_\_\_\_\_

Was the vehicle equipped with airbags?  Yes  No

Attorney Address: \_\_\_\_\_

If yes, did they inflate properly?  Yes  No

Attorney Phone Number: \_\_\_\_\_

Did your seat have a headrest?  Yes  No

If yes, what was the position of the headrest?

**POLICE**

Low  Midposition  High

Did the police come to the accident site?  Yes  No

**OTHER VEHICLE**

Were there any witnesses?  Yes  No

Make and Model of other vehicle: \_\_\_\_\_

Was a police report filed?  Yes  No

Which direction was other vehicle traveling? \_\_\_\_\_

Was a traffic violation issued?  Yes  No

Speed other vehicle was traveling: \_\_\_\_\_

If yes, to whom? \_\_\_\_\_

Name of other driver: \_\_\_\_\_

## IMPACT

Did your vehicle impact another vehicle?  Yes  No

Did your vehicle impact a structure?  Yes  No

If yes, please explain: \_\_\_\_\_

Did any part of your body strike anything in the vehicle?

Yes  No If yes, explain: \_\_\_\_\_

Was impact from:  Front  Rear  Left  Right

Other \_\_\_\_\_

At time of impact were you looking:

Straight ahead  Left  Right  Down  Up

Were both hands on the steering wheel?  Yes  No

If no, which hand was on the wheel?  Left  Right

Was your foot on the brake?  Yes  No

If yes, which foot was on the brake?  Left  Right

## PATIENT CONDITION

Were you:  Surprised by impact  Braced for impact

Were you unconscious immediately after the accident?

Yes  No If yes, for how long? \_\_\_\_\_

Please describe how you felt immediately after the

accident/collision: \_\_\_\_\_

Did you go to the hospital?  Yes  No

When did you go?  Immediately after the accident

Next day  2 or more days after the accident

How did you get to the hospital?

Ambulance  Private transportation

Name of Hospital: \_\_\_\_\_

## TREATMENT

Name of doctor: \_\_\_\_\_ Clinic Name: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Treatment received: \_\_\_\_\_

X-rays taken: \_\_\_\_\_

Other health care professionals seen for this injury: \_\_\_\_\_

## SYMPTOMS/INJURIES

Have you been able to work since this injury?  Yes  No How many work days have you missed? \_\_\_\_\_

Prior to the injury were you able to work on an equal basis with others your age?  Yes  No

Please check appropriate boxes if you have had any of the following symptoms since your injury:

- |   |   |                                       |   |   |
|---|---|---------------------------------------|---|---|
| <input type="checkbox"/> Neck pain      | <input type="checkbox"/> Ear buzzing          | <input type="checkbox"/> Headaches    | <input type="checkbox"/> Arm/shoulder pain    | <input type="checkbox"/> Nausea         |
| <input type="checkbox"/> Neck stiffness | <input type="checkbox"/> Ear ringing          | <input type="checkbox"/> Irritability | <input type="checkbox"/> Chest/rib pain       | <input type="checkbox"/> Stomach upset  |
| <input type="checkbox"/> Back Pain      | <input type="checkbox"/> Fatigue              | <input type="checkbox"/> Jaw problems | <input type="checkbox"/> Shortness of breath  | <input type="checkbox"/> Blurred vision |
| <input type="checkbox"/> Back stiffness | <input type="checkbox"/> Feet/toe numbness    | <input type="checkbox"/> Leg/hip pain | <input type="checkbox"/> Sleep difficulty     | <input type="checkbox"/> Memory loss    |
| <input type="checkbox"/> Dizziness      | <input type="checkbox"/> Hand/finger numbness | <input type="checkbox"/> Knee pain    | <input type="checkbox"/> Facial pain/numbness | <input type="checkbox"/> Tension        |

Is the condition getting progressively worse?  Yes  No  Unknown

How often do you have this pain? \_\_\_\_\_ Is it constant or does it come and go? \_\_\_\_\_

Does it interfere with your:  Work  Sleep  Daily routine  Recreation

Activities or movements that are painful to perform:  Sitting  Standing  Walking  Bending  Laying down

*I certify that this information is correct to the best of my knowledge, and I authorize above listed insurance companies to release privileged information regarding my claim to Market Place Chiropractic Wellness Center as indicated.*

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_