RebarcakChiropractic
PAIN RELIEF CENTER

AUTOMOBILE ACCIDENT REPORT

Today's date_____

Name _____ **Date of accident** _____**Time** _____ **AM/PM**

Our policy is to file with your automobile insurance company under their medical payments or "med-pay" plan.
They will pay claims as they receive them no matter who was at fault. Generally, no payment is due from you.

☐ **Auto Insurance Company:** _____

Address: _____

Policy # _____Claim # _____

Contact Person: _____ Phone: _____

ACCIDENT DETAILS

Description of the accident: _____

_____

_____

_____

Where did the accident take place:_____**City:** _____**State:**_____

Your speed at impact:_____mph **Site of impact on your car: [ ]** front **[ ]** back **[ ]** side R – L **[ ]** corner R - L

Seat belts: [ ] Yes **[ ]** No **Brakes applied: [ ]** Yes **[ ]** No **Air bag: [ ]** Yes **[ ]** No **Did seat break: [ ]** Yes **[ ]** No

Where were you sitting in the car: [ ] driver **[ ]** front seat (middle – right) **[ ]** back seat (left – middle - right)

Road conditions: [ ] wet **[ ]** dry **[ ]** icy **Visibility: [ ]** night **[ ]** day **[ ]** good **[ ]** foggy **[ ]** rainy **[ ]** poor

Was your car: [ ] gaining speed **[ ]** slowing down **[ ]** steady speed **[ ]** stopped **[ ]** other _____

Was the *other* car: [ ] gaining speed **[ ]** slowing down **[ ]** steady speed **[ ]** stopped **[ ]** other _____

Were you aware of the impending impact: [ ] Yes **[ ]** No **Which way were you looking: [ ]** right **[ ]** left **[ ]** front

What part(s) of your body were struck:_____

Type of vehicle you were in:_____ **Vehicle of *other* driver:**_____

Did you lose consciousness: [ ] Yes **[ ]** No **Paramedics notified: [ ]** Yes **[ ]** No **Police notified: [ ]** Yes **[ ]** No

Citations issues: [ ] Yes **[ ]** No to whom: _____ for what: _____

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AFTER THE ACCIDENT

After the accident did you go: [ ] home **[ ]** ER via ambulance **[ ]** ER via own car **[ ]** ER via another person

[ ] work **[ ]** to family doctor **[ ]** to chiropractor **[ ]** to school **[ ]** _____

Doctor's name:_____ Type of doctor:_____ Date:_____

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Diagnostics: X-rays of _____ **[ ]** MRI **[ ]** CAT Scan **[ ]** EMG **[ ]** _____

Treatment: [ ] hospitalized for_____ days **[ ]** surgery **[ ]** bed rest for ____ days **[ ]** brace **[ ]** physical therapy

[ ] medication(s) _____ **[ ]** adjustments **[ ]** ice/heat **[ ]**_____

What symptoms did you immediately feel: _____

What are your present complaints: _____ **[ ]** improving **[ ]** same **[ ]** worse

Severity of pain: 0 1 2 3 4 5 6 7 8 9 10 [0=none 10=severe] **Range or level you have experienced:** _____ [0-10]

Describe the pain: [ ] sharp **[ ]** stabbing **[ ]** dull ache **[ ]** deep ache **[ ]** numbness **[ ]** tingling

[ ] throbbing **[ ]** cramp-like **[ ]** localized **[ ]** other_____ **[ ]** radiating to_____

Percentage of time you have pain: [ ] <25% **[ ]** 25%- 50% **[ ]** 50%-75% **[ ]** > 75% **[ ]** 100% **Work days missed**____

Is your pain worse: [ ] morning **[ ]** day **[ ]** night **What makes the pain worse:**_____

Check any areas that are affected in your normal daily living:

[ ] sleeping **[ ]** lifting **[ ]** recreation **[ ]** walking **[ ]** sitting **[ ]** standing **[ ]** concentration **[ ]** working

Did you have any physical complaints before the accident: [ ] Yes **[ ]** No What:_____

Were those complaints the result of a previous accident: [ ] Yes **[ ]** No Date:_____

Describe details of previous accident: _____

Do you have any concerns we should be aware of? _____

_____