Motor Vehicle Accident Form

Patient Name (Last, First)	*Date*

Accident Details	
Were you the driver or passenger?	□ Driver □ Passenger
Which part of your car was impacted?	□ Front □ Rear □ R side □ L side
Briefly describe the incident, or detail in a drawing:	
How fast was your car traveling?	_____ MPH
How fast was the other car traveling?	_____ MPH
Did you hit your head during the accident?	□ Yes □ No □ Unsure
Were you wearing your seatbelt?	□ Yes □ No □ Unsure
Did the air-bags deploy?	□ Yes □ No □ Unsure
Did you lose consciousness at any point?	□ Yes □ No □ Unsure
Did you notice any bleeding at any point?	□ Yes □ No □ Unsure
Did you feel pain immediately following?	□ Yes □ No □ Unsure
Have you experienced any of the following?	□ Headaches □ Nausea/Vomiting □ Dizziness

Treatment Details	
Please list all hospitals, clinics, practices, and physicians you have gone to for treatment:	
Please check any/all treatments you have received since the accident: □ X-Rays □ MRI □ CT □ Lab Work □ Physical Therapy □ Chiropractic □ Other	
Did you receive any prescriptions for treatment of your injuries?	□ Yes □ No
Are you still receiving regular treatment for your injuries?	□ Yes □ No

Insurance Claim Information	
Insurance Carrier Handling Your Claim	*Claim Number*
Claims Adjuster	*Phone Number*

Patient Signature	
Patient / Parent / Guardian Signature	*Date*

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