ADVANCED CHIROPRACTIC CENTER

6035 Greenback Ln. Citrus Heights, CA 95621

Ph: (916) 580-3277 Fax: (916) 307-5166

Auto Accident Information

Name: _____ Today's Date: _____

Date of the accident: _____ Time: _____ ☐ a.m. ☐ p.m.

Were you the: ☐ Driver ☐ Front Passenger ☐ Rear Passenger

If a traffic violation was issued, to whom was it issued? _____

Number of people in your vehicle at the time of the accident? _____

Did the police come to the accident scene? ..... ☐ Yes ☐ No

Was a police report filed? ..... ☐ Yes ☐ No

What department wrote the report? ..... ☐ CHP ☐ Police.

What city or county? _____

Report number for police report: _____

Were you wearing your seat belt? ..... ☐ Yes ☐ No

Was this vehicle equipped with air bags? ..... ☐ Yes ☐ No

If yes, did they inflate? ..... ☐ Yes ☐ No

In relation to the base of your skull, where was the headrest? ☐ Above ☐ Below ☐ At base of skull

What did your vehicle impact? ..... ☐ Another vehicle ☐ Other

If other, explain: _____

Did any part of your body hit anything in the vehicle? ..... ☐ Yes ☐ No

If yes, please describe: _____

Make and model of the vehicle you were occupying: _____

Name the location / street on which you were traveling _____

In which direction were you headed? ..... ☐ North ☐ South ☐ East ☐ West

What was the approximate speed of your vehicle? _____

Did the impact to your vehicle come from the: ..... ☐ Front ☐ Rear ☐ Right Side ☐ Left Side ☐ Other

During the impact, were you facing: ..... ☐ Right ☐ Left ☐ Forward

Were you ..... ☐ Aware of or ☐ Surprised by the impact?

Make and model of the other vehicle? _____

Direction other vehicle was headed? ..... ☐ North ☐ South ☐ East ☐ West

Speed of the other vehicle: _____

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In your own words, please describe how the accident happened: _____

_____

_____

Did the accident render you unconscious? ..... ☐ Yes ☐ No

If yes, for how long? _____

Please describe how you felt immediately after the accident: _____

Have you gone to a hospital, or seen any other doctor? ☐ Yes ☐ No

If yes, when did you go? ..... ☐ Immediately after accident ☐ The next day ☐ 2 days plus

How did you get there? ..... ☐ Ambulance ☐ Private transportation

Name of Hospital and / or attending doctor: _____

Describe any treatment you received? _____

Were any X-Rays taken? ..... ☐ Yes ☐ No

Was medication prescribed? ..... ☐ Yes ☐ No

Have you been able to work since the injury? ..... ☐ Yes ☐ No

Are your work activities restricted as a result of the accident? ..... ☐ Yes ☐ No

Is your condition getting worse? ..... ☐ Yes ☐ No

Attorney Information:

Have you retained an attorney? ..... ☐ Yes ☐ No

Attorney's Name: _____

His / Her phone number: _____

Insurance Information:

What is the name of *your* auto insurance company?

Is there a claim open for this accident? ☐ Yes ☐ No

If yes, what is your claim number with your insurance company? _____

What is the phone number? _____

Other Driver:

What is the name of the *other driver's* auto insurance company? _____

Do they have a claim open for this accident? ☐ Yes ☐ No

If yes, what is your claim number for this insurance company? _____

What is the phone number? _____