

VEHICLE ACCIDENT HISTORY FORM

TODAYS DATE _____ HOME PHONE _____

NAME _____
Last name First name Middle Initial

ADDRESS _____

CITY _____ STATE _____ ZIP _____

SEX ___ MALE ___ FEMALE # OF CHILDREN _____

MARITAL STATUS ___ SINGLE ___ MARRIED ___ WIDOWED ___ DIVORCED

AGE _____ DATE OF BIRTH _____ HEIGHT _____ WEIGHT _____

BEST TIME TO REACH YOU BY TELEPHONE HOME _____ WORK _____

REFERRED BY _____ CURRENT PHYSICIAN _____

EMPOYER

COMPANY NAME _____ OCCUPATION _____

ADDRESS _____ PHONE # _____

CITY _____ STATE _____ ZIP _____

SPOUSE

NAME _____
Last name First name middle initial

YOUR INSURANCE COMPANY _____

INSURANCE COMPANY ADDRESS _____

INSURANCE COMPANY PHONE # _____

CLAIM # _____ CLAIM REP _____

ACCIDENT DATE _____ TIME OF ACCIDENT _____ AM ___ PM ___

CITY & COUNTY ACCDENT TOOK PLACE _____

ADDRESS WHERE ACCIDENT OCCURRED _____

PREVIOUS TREATMENT DC ___ MD ___ OTHER _____

NAME OF TREATING PHYSICIAN(S) _____

DESCRIBE WHAT YOUR TREATMENT CONSISTED OF _____

WERE YOU THE DRIVER __YES__NO WERE YOU THE PASSENGER__YES__NO

IF YOU WERE THE PASSENGER WHERE WERE YOU SEATED? _____

IS THE VEHICLE REGISTERED TO YOU? __YES__NO

IF NOT, WHO IS THE VEHICLE REGISTERED TO? _____

ADDRESS_____PHONE #_____

IS IT A COMPANY OR PRIVATE VEHICLE? _____

MODEL/YEAR/MAKE_____

OWNERS INSURANCE COMPANY _____

(INSURANCE COMPANY ADDRESS)

CLAIM/POLICY #_____ADJUSTER & PHONE #_____

TOTAL # OF PEOPLE IN THE VEHICLE_____ THEIR NAMES_____

WERE YOU WEARING A SEATBELT? __YES__NO

WERE YOU WEARING A SHOULDER HARNESS? __YES__NO

WAS THERE A HEADREST ON YOUR SEAT? __YES__NO

HOW DID THE HEADREST COME UP ON THE BACK OF YOUR NECK, HEAD? _____

IF YOU WERE TURNING, WERE HAND/TURN SIGNALS BEING USED? __YES__NO

THE OTHER VEHICLE

NAME OF THE DRIVER OF THE OTHER VEHICLE_____

DRIVER'S ADDRESS_____

DRIVERS INSURANCE COMPANY _____

POLICY/CLAIM #_____

INSURANCE ADJUSTERS & PHONE_____

WAS THEIR VEHICLE PRIVATE OR COMPANY OWNED? _____

COMPANY NAME_____# PEOPLE IN VEHICLE_____

AT THE SCENE

ROAD CONDITION AT THE TIME OF THE ACCIDENT: WET__ DRY__ ICY__ LOOSE
GRAVEL__ OTHER_____

VISIBILITY AT THE TIME OF THE ACCIDENT: __BRIGHT__CLOUDY__FOGGY__OTHER

WERE THERE ANY OBSTRUCTIONS INVOLVED: (PARKED VEHICLE, MEDIAN, ETC.)

DID THE POLICE COME TO THE ACCIDENT SCENE? __YES__NO

WERE ANY CITATIONS INVOLVED? __YES__NO TO WHOM:

DID ANY PERSON IN THE CAR REQUIRE AN AMBULANCE? __YES__NO

WERE YOU TAKEN TO THE HOSPITAL, WHAT TESTS, X-RAYS WERE DONE?

WHO WAS THE ATTENDING PHYSICIAN _____

WERE YOU GIVEN ANY SPECIAL INSTRUCTIONS _____

WERE MEDICATIONS PRESCRIBED? _____

HAVE YOU BEEN SEEN BY ANYONE ELSE __ YES __ NO; IF YES WHO _____

WERE ANY OF THE VEHICLES INVOLVED MODIFIED IN ANY WAY? _____

DURING THE ACCIDENT

HOW WERE YOU SEATED IN THE VEHICLE (STRAIGHT, TURNED, ETC) _____

WERE YOU AWARE DO THE APPROACHING COLLISION OR DID IT CATCH YOU BY SURPRISE? _____

WHAT WAS THE POSITION OF YOUR HEAD AT IMPACT (STRAIGHT, TURNED)? _____

IF YOU WERE THE DRIVER, DID YOU HAVE TIME TO BRACE YOURSELF __ YES __ NO

WAS YOUR FOOT ON THE BRAKE __ YES __ NO

WAS YOUR CAR STOPPED OR ROLLING? _____

IF MOVING ESTIMATED SPEED _____ MPH

WAS YOUR CAR SLOWING DOWN, GAINGING SPEED, AT A STEADY RATE _____

IF STOPPED, ESTIMATE THE SPEED OF THE OTHER VEHICLE AT IMPACT _____ MPH

IF A PASSENGER DID YOU HAVE TIME TO BRACE YOURSELF? _____

DID YOU LOSE CONSCIOUSNESS UPON IMPACT? __ YES __ NO; IF YES HOW LONG _____

WERE YOU AWARE OF WHAT WAS GOING ON AROUND YOU? __ YES __ NO

PLEASE DESCRIBE TO THE BEST OF YOUR ABILITY WHAT HAPPENED DURING THE ACCIDENT _____

DID YOU HAVE ANY BLEEDING CUTS? _____

WHAT AREAS OF YOUR BODY WERE BRUISED? _____

WERE YOU THROWN ABOUT INSIDE THE VEHICLE? __ YES __ NO

ON WHAT PART OF THE VEHICLE DID THE FOLLOWING BODY PARTS HIT?

HEAD _____

CHEST/BACK _____

RIGHT/LEFT SHOULDER _____

RIGHT/LEFT ARM, ELBOW, WRIST, HAND _____

RIGHT/LEFT KNEE _____

RIGHT/LEFT HIP _____

RIGHT LEFT ANKLE, FOOT _____

OTHER _____

DID YOU HAVE ANY BROKEN BONES? __ YES __ NO EXPLAIN _____

DID ANY OBJECTS IN THE CAR HIT YOU? ___ YES ___ NO EXPLAIN _____

DID ANY PARTS OF THE VEHICLE BREAK DURING THE ACCIDENT? _____

DID YOUR SEATBELT/SHOULDER BELT BREAK ___ YES ___ NO

WERE YOU ABLE TO GET OUT OF THE VEHICLE ___ YES ___ NO

WERE YOU ABLE TO WALK WITHOUT ASSISTANCE ___ YES ___ NO

DESCRIBE ANY PAIN IMMEDIATELY FOLLOWING THE ACCIDENT _____

DESCRIBE ANY PAIN THE FOLLOWING DAY _____

WERE YOU DIZZY ___ YES ___ NO DID YOU FEEL DISORIENTED ___ YES ___ NO

WHAT HAS BEEN THE PROGRESSION OF SYMPTOMS, FROM THE TIME OF THE ACCIDENT UNTIL NOW? _____

HAVE YOU BEEN IN ANY PREVIOUS AUTO ACCIDENTS? LIST THE YEAR AND BRIEFLY EXPLAIN WHAT HAPPENED AND TO WHAT EXTENT YOU WERE INJURED IN EACH ACCIDENT _____

ARE THERE ANY RESIDUALS, PAIN OR DISCOMFORT FROM PREVIOUS ACCIDENTS _____

ARE ANY OF THE PREVIOUS ACCIDENTS YOU WERE INVOLVED IN STILL UNDER LITIGATION ___ YES ___ NO IF YES ATTORNEYS NAME/ADDRESS/PHONE # _____

DO YOU HAVE AN ATTORNEY FOR THIS ACCIDENT? NAME/ADDRESS/PHONE # _____

WHAT IS THE DAMAGE ON YOUR VEHICLE\$ _____

DESCRIBE WHERE YOUR VEHICLE WAS HIT. _____

EXTENT OF DAMAGE TO OTHER VEHICLE(S)\$ _____

WORK INFORMATION

WHERE ARE YOU EMPLOYED? _____

HAVE YOU LOST ANY TIME SINCE THE ACCIDENT _____

ARE YOU ABLE TO PERFORM YOUR REGULAR DUTIES ___ YES ___ NO

ARE YOU ON LIGHT DUTY ___ YES ___ NO

ARE YOU BEING COMPENSATED FOR TIME LOSS ___ YES ___ NO

WILL THIS ACCIDENT AFFECT YOUR ABILITY TO MAINTAIN YOUR CURRENT JOB ___ YES ___ NO

IS THERE ANY OTHER INFORMATION WE SHOULD BE AWARE OF _____

King Chiropractic Clinic, S.E. 15348 SE Division, Portland, OR 97236
Phone: (503)761-9076 Fax: (503)761-9679 www.kingchiroclinic.com

THE ABOVE INFORMATION GIVEN BY ME IS ACCURATE AND COMPLETE.

DATE _____
(SIGNATURE)

I, THE UNDERSIGNED, UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF. I ALSO CLEARLY UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. THE KING CHIROPRACTIC CLINIC WILL PREPARE ANY NECESSARY REPORTS AND FORMS TO ASSIST ME IN MAKING COLLECTION FROM THE INSURANCE CARRIER. I FURTHER UNDERSTAND THAT THERE WILL BE A SERVICE CHARGE OF 1.5% PER MONTH (18% ANNUAL RATE) ON ANY BALANCE OVER 30 DAYS, UNLESS OTHER ARRANGEMENTS HAVE BEEN AGREED TO IN WRITING BY THE KING CHIROPRACTIC CLINIC. ALSO, ACCOUNT BALANCES MUST BE PAID IN FULL WITHIN FOUR MONTHS FROM DATE OF SERVICE. I ALSO UNDERSTAND THAT A 25.00 ADMINISTRATIVE FEE WILL BE CHARGED ON ANY ACCOUNT BALANCE THAT IS SENT TO COLLECTION OR SMALL CLAIMS.

DATE _____