PEARSON
Chiropractic & Rehabilitation
www.pearsonchiropractic.com

MOTOR VEHICLE ACCIDENT INFORMATION

Patient Name _____ Today's Date _____

General Information

DATE OF ACCIDENT _____ / _____ / _____	☐ Patient was the driver—seated in driver's seat	
	☐ Patient was a passenger	**Location:** ☐ Front Seat ☐ Middle Seat ☐ Back Seat
		Position: ☐ Left Side ☐ Middle ☐ Right Side

PATIENT'S VEHICLE	**Type**	☐ Car ☐ Van ☐ Pickup ☐ Truck ☐ Bus ☐ SUV ☐ Motorcycle ☐ Other _____
	Size	☐ Mini ☐ Subcompact ☐ Compact ☐ Mid Size ☐ Full Size
	Action	☐ Stopped ☐ Slowing ☐ Accelerating ☐ Cruising
	Speed (MPH)	**Number of other people in your vehicle**
	Time of Accident	☐ Dawn ☐ Daylight ☐ Dusk ☐ Dark
	Road Conditions	☐ Dry ☐ Damp ☐ Wet ☐ Snow ☐ Ice
	Visibility	☐ Good ☐ Fair ☐ Poor
	Damage	☐ Minimal ☐ Moderate ☐ Extensive ☐ Totaled ☐ Unsure $ _____
	Impact Location	☐ Front ☐ Rear ☐ Side ☐ Left ☐ Right ☐ Other _____

Enter impact information for up to three vehicles or objects.

Impact #1 Information: Object or Vehicle

☐ **Object**	**Name of Object**	
☐ **Vehicle**	**Vehicle Type**	☐ Car ☐ Van ☐ Pickup ☐ Truck ☐ Bus ☐ SUV ☐ Motorcycle ☐ Other _____
	Vehicle Size	☐ Mini ☐ Subcompact ☐ Compact ☐ Mid Size ☐ Full Size
	Damage	☐ Minimal ☐ Moderate ☐ Extensive ☐ Totaled ☐ Unsure
	Impact Location	☐ Front ☐ Rear ☐ Side ☐ Left ☐ Right ☐ Other _____

Impact #2 Information: Object or Vehicle

☐ **Object**	**Name of Object**	
☐ **Vehicle**	**Vehicle Type**	☐ Car ☐ Van ☐ Pickup ☐ Truck ☐ Bus ☐ SUV ☐ Motorcycle ☐ Other _____
	Vehicle Size	☐ Mini ☐ Subcompact ☐ Compact ☐ Mid Size ☐ Full Size
	Damage	☐ Minimal ☐ Moderate ☐ Extensive ☐ Totaled ☐ Unsure
	Impact Location	☐ Front ☐ Rear ☐ Side ☐ Left ☐ Right ☐ Other _____

Impact #3 Information: Object or Vehicle

☐ **Object**	**Name of Object**	
☐ **Vehicle**	**Vehicle Type**	☐ Car ☐ Van ☐ Pickup ☐ Truck ☐ Bus ☐ SUV ☐ Motorcycle ☐ Other _____
	Vehicle Size	☐ Mini ☐ Subcompact ☐ Compact ☐ Mid Size ☐ Full Size
	Damage	☐ Minimal ☐ Moderate ☐ Extensive ☐ Totaled ☐ Unsure
	Impact Location	☐ Front ☐ Rear ☐ Side ☐ Left ☐ Right ☐ Other _____

During Impact Information

Was your seat belt on?	☐ Yes ☐ No	Were the brakes applied?	☐ Yes ☐ No
Did the airbag deploy?	☐ Yes ☐ No	Was your seat broken?	☐ Yes ☐ No
Did your seat back position change?	☐ Yes ☐ No	Did you hit your head?	☐ Yes ☐ No

During Impact Information continued

Head rest position:	☐ Low ☐ Medium ☐ High ☐ No head rest
Did you prepare for the accident?	☐ Unexpected ☐ Expected ☐ Expected and braced
What was your body position?	☐ Straight ☐ Rotated Left ☐ Rotated Right ☐ Unsure ☐ Other _____
Was your body thrown during the accident?	☐ Yes ☐ No
Head position at the time of the accident	☐ Straight ☐ Rotated Left ☐ Rotated Right ☐ Unsure ☐ Other _____
Did you lose consciousness? ☐ Yes ☐ No	For how long?

Body Impact Information

☐ Head ☐ Upper Front Torso ☐ Right Arm ☐ Right Knee ☐ Left Foot
☐ Left Shoulder ☐ Upper Back ☐ Right Elbow ☐ Left Knee ☐ Other _____
☐ Left Arm ☐ Left Leg ☐ Right Hand ☐ Lower Front Torso _____
☐ Left Elbow ☐ Right Leg ☐ Mid Torso ☐ Lower Back
☐ Left Hand ☐ Right Shoulder ☐ Mid Back ☐ Right Foot _____

After Accident Information

Were the police notified? ☐ Yes ☐ No

Immediately after the accident, how did you feel? ☐ Dizzy/dazed ☐ Upset ☐ Weak ☐ Nervous ☐ Headache
☐ Disoriented ☐ Other _____

PAIN: (Indicate if you experienced any pain in these areas immediately following the accident)

☐ Head ☐ Left Hand ☐ Right Shoulder ☐ Mid Back ☐ Right Foot
☐ Neck ☐ Upper Front Torso ☐ Right Arm ☐ Right Knee ☐ Left Foot
☐ Left Shoulder ☐ Upper Back ☐ Right Elbow ☐ Left Knee ☐ Other_____
☐ Left Arm ☐ Left Leg ☐ Right Hand ☐ Lower Front Torso
☐ Left Elbow ☐ Right Leg ☐ Mid Torso ☐ Lower Back _____

NUMBNESS: (Indicate if you experienced any numbness in these areas immediately following the accident)

☐ Left Hand ☐ Left Leg ☐ Left Upper Arm ☐ Left Foot ☐ Other_____
☐ Right Hand ☐ Right Leg ☐ Right Upper Arm ☐ Right Foot

Medical Care

Did you get medical care for this accident before coming to our office? ☐ Yes ☐ No

Time of care	☐ Immediately ☐ Later that day ☐ Next day ☐ Days later: Number of days_____
Transported by	☐ Drove myself ☐ Ambulance ☐ Other _____
Type of doctor you saw	☐ Orthopedist/Chiropractor ☐ Neurologist ☐ Family Doc ☐ ER ☐ Other _____
Admitted to the hospital?	☐ Yes ☐ No
Tests performed	☐ X-Ray ☐ Lab work ☐ MRI ☐ CT Scan ☐ Other _____
Treatment given	☐ Ice Pack ☐ Hot Pack ☐ Cervical Collar ☐ Medication ☐ None ☐ Other _____

Previous Injuries

Have you suffered previous accidents or injuries? ☐ Yes ☐ No

If yes, please specify: _____

Do you have residual pain from previous accidents or injuries? ☐ Yes ☐ No

If yes, please specify: _____

Have you lost time from work as a result of this accident? ☐ Yes ☐ No If yes, what was the last day you worked? _____

What type of work do you do?

Later Symptoms (Please note any symptoms that started AFTER the accident occurred)

HEAD

- ☐ Headache
- ☐ Fainting
- ☐ Dizziness
- ☐ Memory Loss
- ☐ Blurred Vision
- ☐ Ear Pain
- ☐ Light-headedness
- ☐ Double Vision
- ☐ Loss of Vision
- ☐ Bump, Bruise, Laceration
- ☐ Other _____

NECK

- ☐ Radiating Pain in Shoulders or Arms
- ☐ Neck Pain
- ☐ Muscle Spasms
- ☐ Popping in Neck
- ☐ Other _____

SHOULDERS

- ☐ Shoulder joint pain
- ☐ Pain across shoulder
- ☐ Tension in shoulders
- ☐ Muscle spasms in shoulder
- ☐ Can't raise arms above shoulder level
- ☐ Can't raise arms over head
- ☐ Other _____

ARMS AND HANDS

- ☐ Pain in arms
- ☐ Pain in fingers
- ☐ Cold hands
- ☐ Loss of grip strength
- ☐ Pins & needles in hands
- ☐ Pins & needles in fingers
- ☐ Swollen joints in fingers
- ☐ Numbness in left arm
- ☐ Numbness in right arm
- ☐ Other _____

CHEST

- ☐ Chest pain
- ☐ Breast pain
- ☐ Pain around ribs
- ☐ Shortness of breath
- ☐ Other _____

ABDOMEN

- ☐ Nervous stomach
- ☐ Nausea
- ☐ Diarrhea
- ☐ Constipation
- ☐ Abdominal Pain
- ☐ Other _____

MID BACK

- ☐ Sharp stabbing
- ☐ Pain
- ☐ Muscle spasms
- ☐ Pain from front to back
- ☐ Pain between shoulders
- ☐ Other _____

LOWER BACK

- ☐ Sharp stabbing
- ☐ Pain
- ☐ Muscle spasms

Low back pain is worse when:

- ☐ Working
- ☐ Sitting
- ☐ Lifting
- ☐ Bending
- ☐ Stooping
- ☐ Coughing
- ☐ Standing
- ☐ Lying down
- ☐ Other _____

HIPS, LEGS AND FEET

- ☐ Pain in buttocks
- ☐ Pain in hip joint
- ☐ Numbness in toes
- ☐ Leg cramps
- ☐ Pins & needles in legs
- ☐ Feet feel cold
- ☐ Numbness in leg
- ☐ Pain down leg
- ☐ Knee pain
- ☐ Other _____

GENERAL

- ☐ Nervousness
- ☐ Irritability
- ☐ Fatigue
- ☐ Depression
- ☐ Cramping
- ☐ Generally feeling run down
- ☐ Sleep loss: _____ hours per night
- ☐ Other: _____

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AUTO INSURANCE BILLING

If you wish to bill auto insurance, a third party or an attorney for injuries received due to an accident, ***the following questions must ALL be completed fully.***

This Section Pertains to You, Your Auto Insurance and Your Car

Your Name

Your Auto Insurance Claims Office Name

Your Claims Office Address

City State ZIP Phone

Insured Person's Name Policy No. Claim No.

Accident Date Accident Time Accident Location

Make and model of the car you were in

Which side of the car was damaged?

Did the other car strike your car? ☐ Yes ☐ No ☐ Undetermined Were you at fault or issued a citation? ☐ Yes ☐ No

This Section Pertains the Driver(s) of the Other Vehicle(s)

Driver's Name

Auto Insurance Claims Office Name

Claims Office Address

City State ZIP Phone

Insured Person's Name Policy No. Claim No.

Make and model of the other driver(s)' car

Was the other driver at fault? ☐ Yes ☐ No Was the other driver issued a citation? ☐ Yes ☐ No

Your Attorney's Information

Have you retained an attorney? ☐ Yes ☐ No

Attorney's Name

Attorney's Office Address

City State ZIP Phone

This information must be ***complete in full***. Even if you were not at fault, we still need ***your*** auto insurance information completed to determine if you have Personal Injury Protection (P.I.P.) coverage, which is a provision on your policy to pay for medical bills until the time of settlement with the other involved parties' insurance company, who then reimburses your insurance company fully. If applicable, please understand that this is a benefit you pay for, and this is its purpose; in no way will it affect your insurance premium.

Signature Date