Better Life Chiropractic Motor Vehicle Accident-Injury Report

BILLING INFORMATION

Patient name: _____
Date of Injury: _____Time of Injury: _____ ☐ AM ☐ PM
City and street where crash occurred: _____
What is the estimated damage to your vehicle? $_____
☐ Yes ☐ No Did the police come to the accident scene and make a report?
☐ Yes ☐ No Is an attorney representing you? Name/address/phone: _____
_____

Your auto insurance information

☐ Yes ☐ No Do you have automobile medical insurance coverage?
Name of insurance _____
Address _____
Phone number _____
What is your car insurance medical coverage limit? $_____
What is the claim number? _____
☐ Yes ☐ No Do you know the claim adjuster's name? _____
☐ Yes ☐ No Have you reported this injury to your car insurance company?

Other auto insurance information

Name _____
Address _____
Phone number _____
What is the claim number? _____
☐ Yes ☐ No Do you know the claim adjuster's name? _____
☐ Yes ☐ No Have you reported this injury to the other car insurance company?

AUTO ACCIDENT DESCRIPTION

Describe how the crash happened

_____
_____
_____
_____
_____
_____
_____
_____
_____

Collision Description

Check all that apply to you:

☐ Single-car crash	☐ Two-vehicle crash	☐ More than three vehicles
☐ Rear-end crash	☐ Side crash	☐ Rollover
☐ Head on crash	☐ Hit guardrail/tree	☐ Ran off road

You were the

☐ Driver	☐ Front Passenger	☐ Rear Passenger

Describe the vehicle you were in

Model year and make: _____

☐ Subcompact car ☐ Compact car ☐ Mid-sized car
☐ Full-sized car ☐ Pickup truck ☐ Larger than 1-ton vehicle

Describe the other vehicle

Model year and make: _____

☐ Subcompact car ☐ Compact car ☐ Mid-sized car
☐ Full-sized car ☐ Pickup truck ☐ Larger than 1-ton vehicle

Estimated crash speeds

Estimate how fast your vehicle was moving at time of crash. _____mph
Estimate how fast the other vehicle was moving at time of crash. _____mph

At the time of impact your vehicle was

☐ Slowing Down ☐ Stopped ☐ Gaining speed ☐ Moving at a steady speed

At the time of impact the other vehicle was

☐ Slowing Down ☐ Stopped ☐ Gaining speed ☐ Moving at a steady speed

During and after the crash, your vehicle

☐ Kept going straight, not hitting anything
☐ Kept going straight, hitting car in front
☐ Was hit by another vehicle
☐ Spun around, not hitting anything
☐ Spun around, hitting another car
☐ Spun around, hitting object other than car

Describe yourself during the crash

Check only the areas that apply to you:

☐ You were unaware of the impending collision.
☐ You were aware of the impending crash and relaxed before the collision.
☐ You were aware of the impending crash and braced yourself.
☐ Your body, torso, and head were facing straight ahead.
☐ You had your head and/or torso turned at the time of collision:
  ☐ Turned to left ☐ Turned to right
☐ You were intoxicated (alcohol) at the time of crash.
☐ You were wearing a seat belt.
  If yes, does your seat belt have a shoulder harness? ☐ Yes ☐ No
☐ You were holding onto the steering wheel at the time of impact.

Indicate if your body hit something or was hit by any of the following:

Please draw lines and match the left side to the right side.

Head	Windshield
Face	Steering Wheel
Shoulder	Side door
Neck	Dashboard
Chest	Car Frame
Hip	Another occupant
Knee	Seat
Foot	Seat belt
	Airbag

Check if any of the following vehicle parts broke, bent, or were damaged in your car

☐ Windshield ☐ Seat frame ☐ Knee Bolster
☐ Steering wheel ☐ Side/rear window ☐ Other _____
☐ Dashboard ☐ Mirror ☐ Other _____

Rear-end collisions only
Answer this section only if you were hit from the rear.
Does your vehicle have
☐ Movable head restraints
☐ Fixed, non-movable head restraints
☐ No head restraints
Please indicate how your head restraint was positioned at the time of the crash.*
☐ At the top of the back of your head
☐ Midway height of the back of your head
☐ Lower height of the back of your head
☐ Located at the level of your neck
☐ Located at the level of your shoulder blades (upper back) below neck

*Estimate the distance between the back of your head and the front of the head restraint. _____inches

All types of collisions
Answer this section regardless of the type of crash, indicating those relevant to your case.

Yes	No	
☐	☐	Did any of the front or side structures, such as the side door, dashboard, or floor board of the car, dent inward during the crash?
☐	☐	Did the side door touch your body during the crash?
☐	☐	Were you hands on the steering wheel or dashboard during the crash?
☐	☐	Did your body slide under the seat belt?
☐	☐	Was a door of your vehicle damaged to the point that you could not open the door?

Emergency Department

Yes	No	
☐	☐	Did you go to the emergency department after the accident? What is the name of the emergency department? _____ When did you go (date and time)? _____
☐	☐	Did you go to the emergency department in an ambulance?
☐	☐	Did you or another person drive you to the emergency department?
☐	☐	Were you hospitalized over night?
☐	☐	Did the emergency department doctor take X-rays? Check what was taken: ☐ Skull ☐ Neck ☐ Low back ☐ Arm or leg
☐	☐	Did the emergency department doctor give you pain medication?
☐	☐	Did the emergency department doctor give you muscle relaxants?
☐	☐	Did you have any cuts or lacerations?
☐	☐	Did you require any stitching for cuts?
☐	☐	Were you given a neck collar or back brace to wear?

When did you first notice any pain after the injury?
☐ Immediately ☐ _____Hours after injury ☐ _____Days after the injury

If you did not see a doctor for the first time within the first week, indicate why
Check all that apply

☐ No pain was noticed
☐ No transportation
☐ No appointment schedule available
☐ Work/Home schedule conflicts

If you did not see a doctor for the first time within the first month after injury, indicate why
Check all that apply

☐ No pain was noticed
☐ No transportation
☐ I thought pain would go away
☐ I self-treated with over-the-counter drugs
☐ No appointment schedule available
☐ Work/home schedule conflicts
☐ I had no insurance or money
☐ I took hot showers, used ice, heat

Have you been unable to work since injury?
☐ Yes ☐ No If yes, you were off work ☐ partially or ☐ completely
Please list date off work: _____ to _____.

I understand and agree that accident insurance policies are an arrangement between the insurance company and myself, regardless of my insurance status. I am ultimately responsible for the balance of my account for any professional services rendered. Furthermore, I understand that Better Life Chiropractic will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to Better Life Chiropractic will be credited to my account upon receipt. I also agree that Better Life Chiropractic has a lien for chiropractic services rendered as a result of the accident that occurred on _____against any settlement for personal injuries I may receive.

Patient Signature or legal guardian if minor _____
Date_____

Website Membership Enrollment

The information on our website will help you

Get Well and Stay Well.

Please provide the following details so we can establish you as a member of our website today:

First name: _____

Last name: _____

Date of birth: _____ / _____ / _____

Email address: _____

Please check the health subjects that most interest you:

- ❑ Headaches and Neck Pain
- ❑ Backaches and Sciatica
- ❑ Children's Health Issues
- ❑ Exercise and Fitness
- ❑ Diet and Nutrition
- ❑ Stress Management
- ❑ Wellness Topics
- ❑ Women's Health Issues

By joining our website, you authorize us to send occasional health care related emails to you. Naturally, you may opt-out at any time. Please review our complete privacy policy on our website.

Lifecycle:	
Chiropractor:	