Sheradin
CHIROPRACTIC
CENTER P.C.

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VEHICLE COLLISION INFORMATION

Patient Name_____ Date_____

Your Information

Your Insurance Co._____ Your Agent_____

Phone # _____ Policy # _____ Claim #_____

Make and Model / Year of vehicle **you were in** _____

Were you the: □ Driver □ Front Passenger □ Rear Passenger □ Pedestrian

Of people that were in your vehicle during the collision _____

Driver of vehicle **you were in** (if other than self) _____

Driver's Insurance Co._____ Phone #_____ Policy #_____

Have you retained an attorney? □ No □Yes

If YES Attorney Name_____ Phone _____

Other Driver Information

Name of driver of other vehicle_____

Insurance Co._____ Phone #_____ Policy #_____

Make and Model / Year of vehicle_____

Collision Site

Road/Street Name_____ City/State_____

Nearest Intersection with road/street_____

Were driving conditions? □ Dry □ Wet □ Icy □ Other: _____

Weather: □ Sunny □ Cloudy □ Raining □ Other: _____

Date of Collision: _____ Time: _____ am/pm

Impact

Please describe the accident in your own words: _____

_____

_____

Did your car impact another vehicle? □ No □ Yes If yes, explain?_____

Did your car impact another structure? □ No □ Yes If yes, explain?_____

Impact (continued)

Was impact from □ Front □ Rear □ Right □ Left □ Other: _____

Did any part of your body strike anything in the vehicle? □ No □ Yes

If yes, explain: _____

At time of impact, were you looking: □ Straight □ Left □ Right □ Up □ Down

Speed your vehicle was traveling _____ Speed other vehicle was traveling _____

Were you wearing a seatbelt? □ No □ Yes if yes, what type? □ Lap □ Shoulder

Was vehicle equipped with airbags? □ No □ Yes If yes, did they inflate properly? □ No □ Yes

Did your seat have a headrest? □ No □ Yes If yes, what position was it in? □ Low □ Mid □ High

Were both hands on the steering wheel? □ No □ Yes If no, which hand was on the wheel?□ Right □ Left

Was your foot on the brake? □ No □ Yes Were you: □ Surprised by impact □ Braced for impact

Did the police come to the accident site? □ No □ Yes

Were there any witnesses? □ No □ Yes

Was a traffic violation issued? □ No □ Yes If yes to whom? _____

Patient Condition

Were you unconscious immediately after the accident? □ No □ Yes If yes, for how long? _____

Please describe how you felt immediately after the accident: _____

_____

_____

Have you been able to work since the injury? □ No □ Yes If no, how many days have you missed _____

Prior to the injury, were you able to work on an equal basis with others your age? □ No □ Yes

Treatment

Did you go to the hospital? □ No □ Yes If yes, when? □ Immediately after □ Next day □ 2 days after

How did you get to the hospital? □ Ambulance □ Private Transportation

Name of Hospital: _____ Phone#_____

Name(s) of physicians seen: _____

Diagnosis: _____

Treatment received_____

Were x-rays taken (MRI, CT)? □ No □ Yes If yes, where/when? _____

I certify that the above information is correct to the best of my knowledge.

Patient Signature_____ Date_____