core chiropractic

116 West Neider Avenue
Coeur d'Alene, ID 83815

p: 208 664 0800
f: 208 664 0820

w: core-chiropractic.com
e: ajoubert@core-chiropractic.com

AUTOMOTIVE CRASH FORM

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? $ _____

(Write Y for yes and N for no)

____ Do you have automobile medical insurance coverage?
Name/address/phone of insurance company: _____

_____

_____

____ What is your car insurance medical coverage limit? $ _____
____ What is the claim number? _____

(Write Y for yes and N for no)

Do you know the claims adjuster's name? If so please indicate here: _____
Have you reported this injury to your car insurance company: _____
Did the police come to the accident scene and make a report: _____
Is an attorney representing you? Name/address/phone: _____

_____

_____

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-size car
___ Full-size car ___ Pickup truck ___ Larger than 1 ton vehicle

Describe the other vehicle
___ Subcompact car ___ Compact car ___ Mid-size car
___ Full-size car ___ Pickup truck ___ Larger than 1 ton vehicle

Road conditions at time of collision
___ Dry ___ Wet ___ Icy ___ Snow covered.

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 ___ Spun around, not hitting anything
___ Kept going straight, hitting car in front ___ Spun around, hitting car in front or other vehicle
___ Was hit by another vehicle ___ 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 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 the 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
___ Food	___ Seat belt

Check if any of the following 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 restraints. _____ inches.

All types of collisions

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

(write Y for yes and N for no)

___ Did any of the front or side structures, such as the side door, dashboard, or floor board of your car, dent inward during the crash?
___ Did the side door touch your body during the crash?
___ Were your 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 where you could not open it?

Emergency department

(write Y for yes and N for 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 by ambulance?
___ Did you or another person drive you to the emergency department?
___ Were you hospitalized overnight?
___ 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 medications? Please describe:_____

_____

_____

___ 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 injury?

___ Immediately ___ Hours (how many) after injury ___ Days (how many) after 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 appointment schedule available
___ No transportation ___ 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/s off work: _____ to_____.

Patient Signature: _____ Date:_____