

AUTO ACCIDENT INJURY FORM

Name: _____ Claim # _____

Date of Accident: _____ Time of Accident: _____

Were Seatbelts in use? _____ Chest type _____ Lap type _____

Were headrests in use? _____

Where were you located in your vehicle? _____

Were there any other people in the vehicle? _____

What was the direction that your vehicle was hit from? (Describe) _____

What type of vehicle were you in? _____

What type of vehicle(s) were involved other than yours? _____

Road Conditions: Dry _____ Wet _____ Icy _____

Was your vehicle: Moving _____ Stopped _____

Were brakes on at the time of the accident? _____ Did you see the accident coming? _____

How did you feel immediately after the accident? (Please describe) _____

How did you feel the next day? _____

Did you miss any work? _____ If yes, please give dates _____

Who was the first to examine you and treat you following the accident and when? _____

Were you ever involved in a previous motor vehicle accident? (Please describe) _____

Have you previously experienced problems in the area(s) currently aggravated? _____

Have you contacted an Insurance Adjuster regarding this accident? _____

Adjusters name and phone number: _____

***Patient assumes responsibility of payment until ICBC coverage is in effect, at which time the patient will be reimbursed**

Patient's Signature: _____ Date: _____



Guildford Chiropractic