Raef Chiropractic and Wellness
402 15th St
Canyon, TX 79015
Phone: (806) 655-1108

AUTO ACCIDENT FORM

ABOUT YOU

Today's Date: _____

Name: _____ Age: _____

Birthdate: _____ Sex: _____ SSN: _____ DL#: _____

Home Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Do you prefer to be reached by:
☐Home ☐Cell ☐Work

Employer: _____ Occupation: _____

NATURE OF ACCIDENT

Date of Accident: _____ Time of Day: _____

Were you: ☐Driver ☐Passenger ☐Front Seat ☐Back Seat

Number of people in your vehicle? _____ Were you wearing seatbelts? ☐Yes ☐No

What direction were you headed? ☐North ☐East ☐South ☐West on (name of street): _____

Were you struck from: ☐Behind ☐Front ☐Left Side ☐Right Side

Approximate speed of car: _____ mph Other car: _____ mph

Was your vehicle: ☐Stopped to make a turn ☐Stopped for a traffic signal ☐Parked
☐Moving at the time of impact ☐Other: _____

Are you licensed to drive? ☐Yes ☐No

Were you in your own car or someone else's at the time of accident? Check one:

☐My own vehicle ☐My spouse's ☐My parents ☐A friend's ☐Other: _____

If you were in someone else's at the time of accident, answer the following:

Owner's Name: _____

Owner's Address: _____

Owner's Phone #: _____

Were the police notified? ☐Yes ☐No Do you have a copy of the police report? ☐Yes ☐No

Who received the ticket/citation? _____

Do you have any "courtesy slips" or other information concerning
the other partied involved in the accident? ☐Yes ☐No

In your own words, please describe the accident: _____
_____
_____
_____

SYMPTOMS AFTER ACCIDENT

Were you knocked unconscious? ☐Yes ☐No

Were you looking: ☐Straight ahead ☐To the left ☐To the right

Have you been x-rayed since the accident? ☐Yes ☐No

Did you have any physical complaints BEFORE THE ACCIDENT? ☐Yes ☐No
_____
_____
_____

Please describe how you felt:

a) DURING the accident: _____
b) IMMEDIATELY AFTER: _____
c) LATER THAT DAY: _____
d) THE NEXT DAY: _____

What are your PRESENT complaints and symptoms? _____
_____
_____

Do you have any congenital (from birth) factors which relate to this problem? ☐Yes ☐No
If yes, please describe: _____
_____
_____

Do you have any previous illnesses which relate to this case? ☐Yes ☐No

Since the accident occurred, are your symptoms: ☐Improving ☐Getting Worse ☐Same

CHECK THE SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

__ Headache	__ Irritability	__ Numbness in Toes	__ Face Flushed	__ Feet Cold
__ Neck Pain	__ Chest Pain	__ Shortness of Breath	__ Buzzing in Ears	__ Hands Cold
__ Neck Stiff	__ Dizzinness	__ Fatigue	__ Loss of Balance	__ Stomach Upset
__ Depression	__ Fainting	__ Constipation	__ Back Pain	__ Cold Sweats
__ Loss of Memory	__ Loss of Taste	__ Loss of Smell	__ Nervousness	__ Ears Ringing

Do you notice any activity restrictions as a result of this injury? ☐Yes ☐No
If yes, please describe: _____
_____
_____

INSURANCE INFORMATION

Insurance Company Name: _____
Policy Number: _____ Phone #: _____

Have you been contacted by an adjuster from the other party's insurance company regarding this claim? ☐Yes ☐No

Name of Adjuster: _____ Phone #: _____

Have you lost time from work as a result of this accident? ☐Yes ☐No

a) Last day worked: _____
b) Type of employment: _____
c) Present Salary: _____
d) Are you being compensated for time lost from work? ☐Yes ☐No