Motor Vehicle Collision Information

Today's Date:_____

Patient Name:_____

Accident Information

Date of Accident:_____ Time of Day:_____

Number of people in the vehicle:_____ ☐ Driver ☐ Passenger

What direction were you headed: ☐ North ☐ South ☐ East ☐ West

Location of accident (closest intersection):_____

City of accident:_____ State:_____

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

Were you wearing a seatbelt? ☐ Yes ☐ No

Were airbags deployed? ☐ Yes ☐ No Were Police Notified ☐ Yes ☐ No

In your own words, please describe the accident:

_____

_____

_____

Were you knocked unconscious? ☐ No ☐ Yes If yes, for how long?_____

What effects did the accident have upon you (physically & emotionally)?
During the accident:_____

Immediately after the accident:_____

Later that day:_____

The next day:_____

What are your present complaints & symptoms?

_____

_____

_____

Where were you taken after the accident?

_____

Have you been treated by another doctor since the accident? ☐ No ☐ Yes

If yes, who?_____ Phone#:_____

What types of treatment did you receive?_____

_____

Were you given any medications? If yes, please list_____

_____

Have you self-treated? If yes, how? _____

Why did you come to us? _____

What are your expectations of us? _____

catalyst chiropractic and rehabilitation
3300 SW Hocken Ave. Suite 108 Beaverton, Oregon 97005
ph. 503 526-8782 fx. 503 526-8721

Work Information

As a result of the accident, have you lost work time? ☐ No ☐ Yes

If no, please go to the "relationships" section of this form. If yes, please complete the following three questions.

What specific duties do you perform at work (i.e. sitting, lifting, walking…):

_____

_____

_____

Have you noticed any limitations when performing your job? ☐ No ☐ Yes

If yes, please explain:_____

_____

_____

Are you concerned about the effects of this accident on your job? ☐ No ☐ Yes

If yes, please explain:_____

_____

_____

Relationship Information

Have you noticed any new or increasing stresses at home with your significant other, children, siblings, parents, co-workers? ☐ No ☐ Yes If yes, please explain:_____

_____

_____

Are you able to manage, or do you need assistance?_____

Personal Life Information

Have you had any difficulties performing everyday activities (i.e. grooming, bathing, childcare, reading, shopping, driving…)? ☐ No ☐ Yes If yes, please explain:_____

_____

_____

Have you had any difficulties performing recreational activities/hobbies (i.e. working out at the gym, hiking, tennis, golf, swimming, yoga…)? ☐ No ☐ Yes

If yes, please explain:_____

_____

_____

Have you had to hire anyone to help you with your responsibilities? ☐ No ☐ Yes

Who else has helped you and in what way?_____

_____

Personal Injury Insurance Information

Today's Date:_____ Patient Name:_____

Date of Accident:_____ Time of Day:_____ # of people in the vehicle:_____ ☐ Driver ☐ Passenger

Medical Payment Coverage

On your automobile insurance, or the automobile insurance for the car in which you were a passenger, there may be covered called "PIP" (Personal Injury Protection) or "Med-Pay." This coverage is for any injuries that may have occurred to someone in the automobile. It will cover anything from an automobile accident that either was or wasn't your fault, to slamming your finger in the car door.

Policy Holder's Name:_____Insurance Company's Name:_____

Insurance Address:_____

Insurance Phone:_____

Policy#:_____ Claim#:_____

Third Party Liability

This is the insurance information for the person who was in the "other car." The information can be found on the Accident Report.

Driver's Name:_____

Driver's Address:_____

Policy's Holder's Name:_____

Insurance Company's Name:_____

Insurance Address:_____

Insurance Phone:_____ Policy#:_____

Claim#:_____

Attorney Information

Do you have an attorney? ☐ No ☐ Yes

Attorney Name:_____ Firm:_____

Contact Person:_____ Phone#:_____

By signing below, I acknowledge that I have provided all the requested information to the best of my knowledge and I understand all the information explained to me on this form.

_____ _____

Patient Signature Date

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