BLAINE CHIROPRACTIC & MASSAGE

Motor Vehicle Accident and Injury Intake Form

Name: _____ DOB _____ Date: _____

Insurance Information:

Name of Insurance Company:

_____

Claims #: _____

Adjusters Name: _____

Phone # to reach Adjuster:_____

Claim open for Medical Billing: YES NO

Claims Filing Address:

_____

Other Party Insurance Company (If Applicable):

Name of Insurance Company: _____

Ins Phone #: _____

Secondary Claim #:

_____

At Fault Party's Name: _____

Phone #: _____

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ACCIDENT HISTORY:

Date of Accident: _____ Time of Accident: _____ AM or PM

State how the accident happened in your own words:

_____

_____

_____

Please describe where your car was damaged to the best of your ability.

_____

ACCIDENT HISTORY:

Type of Vehicle: _____Year of Vehicle:_____

Were you driving the car? YES NO If NO, who was? _____

Did your vehicle strike anything else? (Tree, another car, side railing, etc.)_____

What were the weather conditions like?

_____

How fast were you driving?

_____

Were you driving distracted?

_____

Were you wearing a seatbelt? YES NO

Did the Air Bags go off? YES NO

Did Police arrive at the accident? YES NO

Did EMS arrive at the accident? YES NO

What was the extent of damage done to your car?

_____

What was the other type of vehicle involved in the accident? _____ Year_____

What was the extent of damage done to the other car? (If known)

_____

INJURY HISTORY:

Did you hit any part of your body during the collision? (Head hit dashboard, chest hit steering wheel, etc.)

_____

_____

Where are you feeling the pain now?

Condition #1 Main complaint:

_____

Condition #2: Second complaint:

_____

Condition #3: Third complaint:

_____

Condition #4: Fourth complaint:

_____

Please Rate the Pain of the complaints in the order listed above from 0-10:

Please Rate the Frequency at which you experience the pain throughout the day 0-100%: