York Chiropractic Clinic

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Auto Accident Report Form

Name:_____ Time of Incident:_____ □ a.m □ p.m

Date of Accident: _____City of Accident:_____

Street of Accident: _____Cross Street (Intersection): _____

Road conditions at the time of the incident: □ Wet □ Dry □ Icy □ Other _____

Did the police come to the scene of the accident? □ Yes □ No

Was an accident report filed? □ Yes □ No

Were you taken to a hospital? □ Yes □ No

Hospital Name & City: _____

How did you get to the hospital? _____

Were X-Rays taken? □ Yes □ No

If yes, what was X-Rayed? □ Head □ Neck □ Upper Back □ Mid-Back □ Lower Back

If auto accident, you were the □Driver □ Passenger □ Pedestrian

If auto Collison you were struck from □Behind □ Right Side □ Left side □ Front □ Auto was parked

Did your car strike the other(s) involved? □ Yes □ No Did the other car strike yours? □ Yes □ No

List the extent of injuries as you know them

Head:_____
Chest:_____
R/L Shouder:_____
R/L Arm:_____
R/L Hip:_____
R/L Leg:_____
R/L Knee:_____

Other:_____

CHECK SYMPTONS YOU HAVE NOTICED SINCE ACCIDENT:

□ Headache	□ Irritability	□ Numbness in Toes	□ Face Flushed	□ Feet Cold
□ Neck Pain	□ Chest Pain	□ Shortness of Breath	□ Buzzing in Ears	□ Hands Cold
□ Neck Stiff	□ Dizziness	□ Fatigue	□ Loss of Balance	□ Fever
□ Nervousness	□ Cold Sweats	□ Upset Stomach	□Loss of Taste	□ Diarrhea
□ Sleeping Problems	□ Head Seems too Heavy	□ Depression	□ Fainting/ Light Headed	□ Constipation
□ Back Pain	□ Pin & Needles in Legs	□ Pins & Needles in Fingers		□ Loss of smell
□ Loss of Memory	□ Lights bothers eyes	□ Earrings ring		

□ Other_____

Have you lost any days of work? □ Yes □ No Dates_____

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Personal Injury Form

My Insurance Company or Law Firm Name

_____

Person responsible for injuries Insurance Company or Law Firm Name

_____

Have you been contacted by an insurance adjuster or company representative regarding the claim? □ Yes □ No

Claim or Case Number:_____

Adjustor or Lawyer Name:_____

Phone Number:_____

Fax Number: _____

Do you have an attorney that has advised you in this case? □ Yes □ No

Atty Name: _____

Address: _____Phone Number:_____

Fax:_____

NOTICE: Having insurance information is not a guarantee that they will cover your fees in full. Whatever your insurance provider does not pay will be your responsibility. If you fail to keep in contact with the insurance company and your case closes before our bill is paid in full, you will be responsible for your balance.