VALENTE CHIROPRACTIC

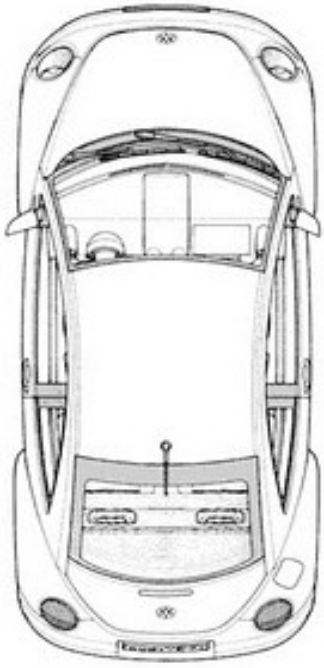
Motor Vehicle Collision Form

Name: _____ **DOB:** _____ **Today's Date:** _____

Report of Accident:

Date of Accident:_____ Time of Accident:_____❑A.M. ❑P.M. City of Accident: _____
Street of Accident that your car was on: _____ Cross Street (intersection): _____
Road conditions at the time of incident: ❑Wet ❑Dry ❑Icy ❑Other _____
Were there any witnesses? ❑Yes ❑No Were you wearing your seat belt? ❑Yes ❑No
Did the police come to the scene of the accident? ❑Yes ❑No Was an accident report filed? ❑Yes ❑No
If a traffic violation was issued, to whom was it issued? _____
Please explain the details of the accident to the best of your knowledge: _____
_____
_____
_____

Indicate where the initial impact struck your vehicle by marking an "X" on the diagram below:



The following questions pertain to you, the patient, and the vehicle you were in:
Number of people in accident vehicle: _____
Were you the: ❑Driver ❑Front Passenger ❑Rear Passenger
Were you ❑aware of the approaching collision ***or*** ❑surprised by impact?
Were you rendered unconscious? ❑Yes ❑No If yes, for how long?_____
Was this vehicle equipped with airbags? ❑Yes ❑No
If yes, did it/they inflate? ❑Yes ❑No
What did your vehicle impact? ❑Another Vehicle ❑Other _____

Vehicle Information & Velocity pertaining to the vehicle you were in:
Vehicle Year: _____ Make:_____ Model: _____
What direction was your vehicle traveling? ❑North ❑South ❑East ❑West
Was your car ❑Moving ***or*** ❑Stopped
If your car was moving:
How fast were you traveling? Approximately _____ MPH
Just before impact, the vehicle you were in was:
❑Slowing down ❑Speeding Up ❑Constant Speed
Did the impact to your vehicle come from the:
❑Front ❑Rear ❑Right Side ❑Left Side ❑Other: _____

The following questions pertain to the other vehicle involved in the accident:
Other Vehicle Year: _____ Make:_____ Model: _____
What direction was the other vehicle traveling? ❑North ❑South ❑East ❑West
Was the other car ❑Moving ***or*** ❑Stopped
If the other car was moving:
How fast was it traveling? Approximately _____ MPH
Just before impact, the other car was:
❑Slowing down ❑Speeding Up ❑Constant Speed

Were there bleeding cuts caused by the accident? ❑Yes ❑No Where: _____
Where there any bruises caused by the accident? ❑Yes ❑No Where:_____
If any part of your body struck anything during the collision please describe what and where: _____
_____
What were the cost of damages to the vehicle you were in? $_____
Which (if any) of the following car parts broke during the accident:
❑Windshield ❑Steering Wheel ❑Front Seat ❑Back Seat ❑Side Window (R/L) ❑Other_____
Was the trunk of your body pointed straight forward at the time of impact? ❑Yes ❑No
If No, which direction was it pointed, and by how much? _____
Was your head pointed straight forward at the time of impact? ❑Yes ❑No
If No, which direction was it turned, and by how much? _____

If you have been involved in previous auto accidents, please list the year of each incident:

_____

Please list any additional information not covered above that we should know about:

_____

_____

_____

Insurance Information:

YOUR INSURANCE INFORMATION:

Do you have PIP (Personal Injury Protection) on your policy: ❑Yes ❑No

Name of Insurance Company:_____
Policy #: _____ Claim #: _____
Insured's Name: _____ DOB: _____
Name of Claim Representative: _____ Telephone #: _____

THE OTHER PARTY'S INSURANCE INFORMATION:

Name of Insurance Company:_____
Policy #: _____ Claim #: _____
Insured's Name: _____ DOB: _____
Name of Claim Representative: _____ Telephone #: _____

Attorney Information:

Name of Attorney/Law Office: _____ Telephone #: _____
Address of Attorney:_____ City: _____ State: _____ Zip:_____

Medical Care:

Have you gone to a Hospital or seen any other Doctor? ❑Yes ❑No
When did you go? ❑Just after accident ❑Next Day Other:_____
Mode of Transportation: ❑Ambulance ❑Privately transported
Name of Hospital and/or Attending Doctor:_____
_____
Was he/she a: ❑D.C. ❑M.D. ❑D.O. ❑D.D.S. ❑P.A.

Were X-Rays taken? ❑Yes ❑No
If yes, what was X-Rayed: _____
_____
Was medication prescribed? ❑Yes ❑No
Describe any treatment you received:
_____

Work:

To evaluate the effect that continuing work will have on your recovery please complete the following:
Have you been able to work since the injury? ❑Yes ❑No

Are your work activities restricted as a result of your injuries sustained? ❑Yes ❑No

How many hours are in your normal work day? _____

What can you do for work with minimum physical effort and for how long? _____❑N/A

Prior to the injury were you capable of working on an equal basis with others your age? ❑Yes ❑No ❑N/A

While in recovery, is there any light duty work you could request? ❑Yes ❑No ❑N/A

Please indicate your daily job duties and any activities in which you are occasionally asked to perform:
❑Standing ❑Sitting
❑Walking ❑Lifting
❑Driving ❑Twisting
❑Crawling ❑Bending
❑Operating equipment ❑Working with arms above head
❑Typing ❑Stooping
❑Other: _____

Patient Signature _____ **Today's Date:**_____