Druzbik Family Chiropractic
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Motor Vehicle Accident (Personal Injury)

Patient Name: _____
Date of Birth: _____
Today's Date: _____
Date of Accident: _____

CIRCLE THE ANSWER THAT APPLIES TO YOU:

Type of Accident Auto Work-Related Other_____

What reports have been filed for this accident? Police report Employer's report of injury
Other _____

Do you have a copy of the report? Yes No
Did you see or sense the accident coming? Yes No
What was your role at the time of the accident? driver passenger pedestrian
on a bicycle on a motorcycle

What direction did the impact come from? behind the front the right the left the rear
What speed were you traveling? _____
What speed was the other driver traveling? _____
In what direction were you looking at the time? straight ahead down to the right to the left
over your shoulder
Immediately following the accident, how did you feel? disoriented/dizzy nauseous tightness
lost consciousness immediate pain
Which of the following happened during the accident? I was wearing a seatbelt the airbag deployed
my vehicle hit another another vehicle hit mine

Did you hit the head rest? Yes No
Did you hit the dashboard? Yes No
Did you go to the hospital? Yes No If yes, which hospital? _____
Were x-rays taken? Yes No Type of x-rays taken _____
Were you given medication at the hospital? Yes No
Type of medication_____
Have you taken time off work as a result of the accident? Yes No
Are you still off work as a result of this accident? Yes No
State of the accident _____
Is there an attorney handling your case? Yes No
Name of Attorney_____
Any other financially involved parties? Yes No
If so, who?_____
Other than your health insurance, are there any other insurance parties involved? Yes No
If so, who? _____
Claim number _____
Phone number_____