



Metcalf Chiropractic Health Center

PO Box 507, 15315 1st Ave NE Suite 5, Duvall, WA 98019 Ph.425-844-6428

Dr. Jeffrey P. Metcalf

Accident Information Form

Patient's Name: _____ **Date:** _____

Your Attorney's Name: _____

Address: _____

Phone #: _____

Your Insurance Information/ PIP Coverage Information:

Name of Policy Holder: _____

Name of Insurance Company: _____

Insurance Company's Address: _____

Insurance Company's Phone #: _____

Insurance Policy Number: _____

Accident Claim Number: _____

Other Driver's Information:

Person responsible for injuries: _____

Name of their Insurance Company: _____

Their Insurance Company's Address: _____

Their Insurance Company's Phone #: _____

Their Insurance Policy Number: _____

Accident Information

Date of Accident: _____

Time of Accident: _____

Street of Accident: _____

City of Accident: _____

Road Conditions:

Wet Dry Icy Other: _____

You were the:

Driver Front seat passenger

Pedestrian Back seat passenger

Were you taken to the hospital?

Yes No

(Hospital name?) _____

If you were taken to the hospital, how did you get there? Ambulance Self

Family/ Friend Other: _____

You were wearing:

No seatbelt Lap seat belt only

Shoulder/ Lap seatbelt

Have you been treated by another Dr. since the accident? Yes No

-If Yes, please list doctor's name:

What type of treatment did you receive?

Upon impact/ collision you were:

Caught by surprise

Aware of the approaching vehicle

Did you lose consciousness?

Yes -for how long? _____

No



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The headrest of your car seat reaches:

Above you head—by how many inches? _____

Below your head-by how many inches? _____

There is no headrest

Make of your vehicle: _____

Model of your vehicle: _____

Year of your vehicle: _____

Size of your vehicle:

small/compact mid-size large

At the time of impact, your car was:

Stopped Moving

How fast do you estimate your speed? _____

Was your foot on the brake at the time of the impact? Yes No

If your vehicle was moving at the time of impact,, were you:

Slowing down Accelerating

Traveling at a steady rate

Were you:

Hit from the BACK of your car

Hit from the RIGHT side of your car

Hit from the LEFT side of your car

Hit from the FRONT of your car

Was your head:

Straight forward

Turned to the RIGHT

Turned to the LEFT

Other: _____

Did any of the following parts of your body strike any part of the car?

Head Chest

Shoulder/ Arm- what side? _____

Knee/ Leg- what side? _____

Steering wheel Back of seat

Other: _____

Did any of the following parts break during the accident?

Windshield Left side window

Right side window

Steering wheel Back of seat

Other: _____

What was the cost of damage to the vehicle **you** were in? _____

Did the police come to the accident?

Yes No

Was a citation/ ticket written?

Yes No (If yes, to whom?)

Have you lost time from work as a result of the accident? Yes No –if yes, what was:

Last day worked? _____

Type of work? _____

Present salary? _____

Are you compensated for your time lost from work? Yes No- if yes what type of compensation? _____



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The following questions pertain to the other vehicle in the accident:

Make of the other car: _____

Model of the other car: _____

Year of the other car: _____

Size of the other car: Small/ compact

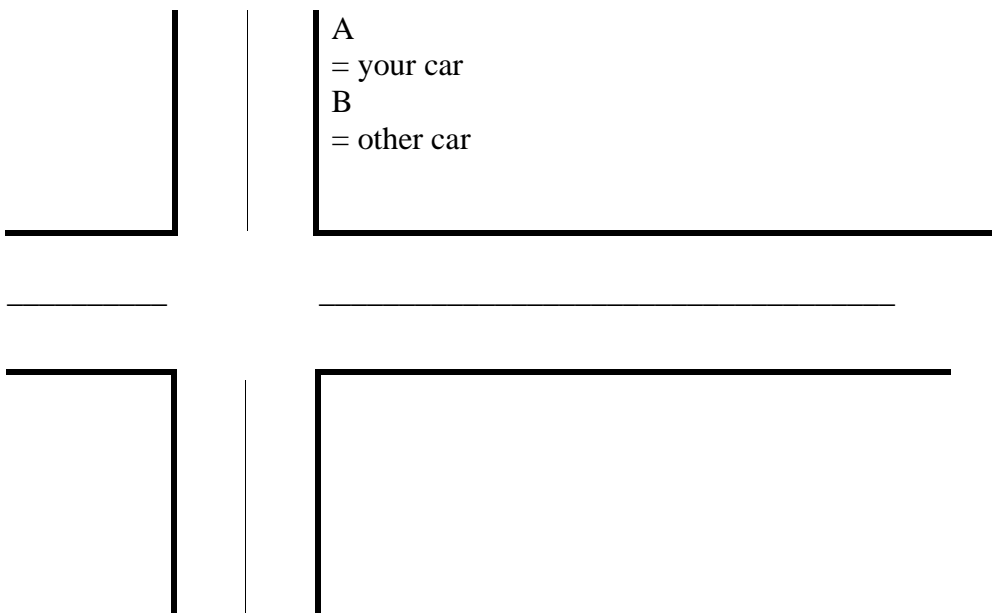
Mid-size Large

At the time of the impact, the other car was:

Stopped Slowing down

Gaining speed Moving at a steady rate

How fast do you estimate the other car's speed? _____



Please describe the accident in your own words. Please use the diagram to indicate the position of the cars involved: _____



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Please describe how you felt:

During the accident: _____

Immediately after the accident: _____

Later that day: _____

The next day: _____

Did you have any physical complaints before the accident? Yes No

If yes, please describe in detail: _____

Have you been involved in an accident before? Yes No

If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received:

Patient's signature: _____ Date: _____