Metcalf Chiropractic Health Center

PO Box 507, 15435 Main St NE, Suite 101, Duvall, WA 98019 Ph. (425) 844-6428
Dr. Jeffrey P. Metcalf

Accident Information Form

Patient's Name: _____ Date: _____

Your Attorney's Name: _____ Phone Number: _____
Attorney's Address: _____

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: _____

Road Conditions:
☐Wet ☐Dry ☐Icy ☐Other: _____

Were you taken to the hospital?
☐Yes (Hospital name?) _____
☐No

If you went to the hospital, how did you get there?
☐Ambulance ☐Self ☐Family/Friend
☐N/A ☐Other: _____

Have you been treated by another doctor since the accident?
☐Yes (Doctor's name?) _____
☐No

If you have been treated, what type of treatment did you receive?
_____
_____

Street of accident: _____
City of accident: _____

You were the…
☐Driver ☐Front seat passenger
☐Pedestrian ☐Back seat passenger

You were wearing…
☐No seatbelt ☐Lap seatbelt only
☐N/A ☐Shoulder/Lap seatbelt

Upon impact/collision, you were…
☐Caught by surprise
☐Aware of the approaching vehicle

Did you lose consciousness?
☐Yes (For how long?) _____
☐No

The headrest of your car seat reaches…
☐Above your head (by how many inches?) _____
☐Below your head (by how many inches?) _____
☐There is no headrest

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Make of your vehicle: _____
Model of your vehicle: _____
Year of your vehicle: _____
Size of your vehicle:
☐Small/Compact ☐Mid-sized ☐Large

At the time of impact, your car was...
☐Stopped
☐Moving (Approx how fast?) _____

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

If your vehicle was moving at the time of impact, were you…
☐Slowing down ☐Accelerating
☐Travelling 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…
☐Turned to the RIGHT ☐Turned to the LEFT
☐Straight forward ☐Other: _____

Have you lost time from work as a result of the accident?
☐No
☐Yes...
Last day worked: _____
Type of work: _____
Present salary: _____
Are you compensated for your time lost?
☐No
☐Yes (What type of compensation?)
_____

Did any of the following parts of your body strike any part of the car?
☐Head ☐Shoulder/Arm (what side?) _____
☐Chest ☐Knee/Leg (what side?) _____

What part of the car did your body hit?
☐Steering wheel ☐Back of seat
☐Other _____

Did any following parts break during the accident?
☐Windshield ☐Left side window
☐Right side window ☐Steering wheel
☐Back of seat ☐Other: _____

Did the police come to the accident?
☐Yes ☐No

Was a citation/ticket written?
☐Yes (to whom?) _____
☐No

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

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-sized ☐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?
_____

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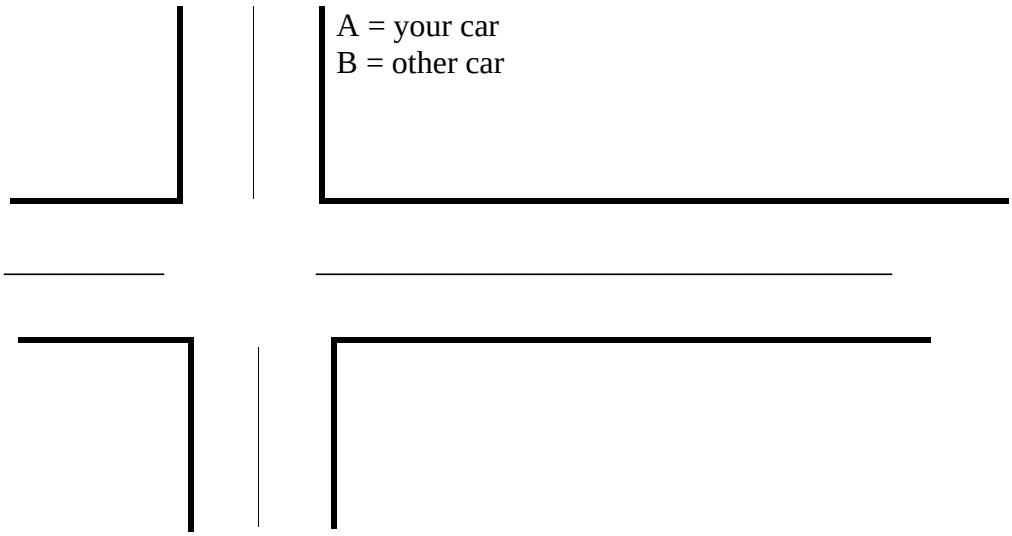

Please describe the accident in your own words. Please use the diagram to indicate the position of the cars involved: _____
_____
_____

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 any injuries received:
_____
_____
_____
_____
_____

Patient's signature: _____ Date:_____