ADVANTAGE
SPINAL DYNAMICS

NAME: _____ DATE: _____

~Please answer all questions completely~

DEAR PATIENT: This information is considered confidential. Please be as neat and accurate as possible. Thank you.

ACCIDENT INFORMATION

DATE: _____ TIME: _____ LOCATION: _____

What did your vehicle impact? _____

PATIENTS CAR: (Make & Model) _____

Were you the: (Circle) *Driver Front Passenger Rear Passenger*

OPPOSING CAR: (Make & Model) _____

Was your vehicle equipped with airbags? *YES or NO* Did they inflate? *YES or NO*

Were you wearing a seatbelt? *YES or NO*

Were you aware of the approaching collision? _____

Where did the impact come from? (Circle) *Front Rear Right side Left side Other:* _____

Patient's vehicle movement? (Circle) *Backing Up Stopped Forward Turning Left Turning Right*

If stopped, was your foot on the brake? *YES or NO*

Opposing vehicle's movement? (Circle) *Backing Up Stopped Forward Turning Left Turning Right*

Patient's vehicle speed? _____ Opposing vehicle's speed? _____

Which direction was the opposing vehicle headed? (Circle) *North South East West*

Which direction was the patient's vehicle headed? (Circle) *North South East West*

What was the estimated damage of the patient's vehicle? _____

Was the patient's vehicle towed from the scene? (Circle) *YES or NO*

What was the estimated damage of the opposing vehicle? _____

Was the opposing vehicle towed from the scene? (Circle) *YES or NO*

At the time of the collision, which direction were you facing? _____

In relation to the base of your skull, where was the headrest? _____

Did any part of your body strike anything in the vehicle? (Circle) *YES or NO*

If yes, please list all parts of your body that made contact and with what part of the vehicle's interior._____

_____

_____

Did you receive a head injury due to the accident? (Circle) *YES or NO*

Did you lose consciousness (black out) upon impact? (Circle) *YES or NO*

Please describe in detail, to the best of your knowledge, what happened during this accident:

_____

_____

_____

_____

_____

PATIENT INFORMATION

PATIENT'S AUTO INSURANCE CO.:_____

POLICY #:_____ CLAIM #:_____

NAME OF YOUR INSURANCE ADJUSTER: _____

PHONE #:_____ FAX #:_____

INSURANCE ADDRESS: _____

HAVE YOU RETAINED AN ATTORNEY? (Circle) *YES or NO*

ATTORNEY NAME: _____ CLAIM#:_____

Name the driver of the vehicle if you were the passenger: _____

Drivers insurance co.:_____ Policy #:_____ Claim #:_____

Insurance adjuster:_____ Claim#:_____

OPPOSING DRIVER INFORMATION

OPPOSING DRIVER NAME: _____

PATIENT'S AUTO INSURANCE CO.:_____

POLICY #:_____ CLAIM #:_____

NAME OF YOUR INSURANCE ADJUSTER: _____

PHONE #:_____ FAX #:_____

INSURANCE ADDRESS: _____

MEDICAL INFORMATION

Did EMS come to the accident scene? (Circle) *YES or NO*

Did you go to the hospital or see any other doctor? (Circle) *YES or NO*

If yes, name of hospital and/or attending doctor._____

Was he/she a: (Circle) *D.D.S. M.D. D.C. D.O.*

When did you go to the hospital? _____

How did you get to the hospital? _____

Was medication prescribed? (Circle) *YES or NO* Were X-Rays taken? (Circle) *YES or NO*

What treatment was given? _____

What was the diagnosis? _____

Have you been able to work since this injury? (Circle) *YES or NO*

Are your work activities restricted as a result of this injury? (Circle) *YES or NO*

Please describe how you felt immediately after the accident: _____

_____

_____

LEGAL INFORMATION

Did the police come to the accident scene? (Circle) *YES or NO*

Was a police report filed? (Circle) *YES or NO*

Was a traffic violation issued? (Circle) *YES or NO* To whom? _____