DALLAS CHIROPRACTIC METRICS

AUTOMOBILE ACCIDENT INFORMATION

Was anyone else in the car with you? ☐ No ☐ Yes How many_____
Position in car ☐ Driver ☐ Front Passenger ☐ Back Seat
Name of driver if not self_____ Name of other driver_____
Did the air bags deploy ☐ No ☐ Yes
Did the police arrive ☐ No ☐ Yes **Seatbelt** ☐ No ☐ Yes
Did you strike any object/person in the car ☐ No ☐ Yes
Did you remain conscious ☐ No ☐ Yes
Where was your vehicle impacted ☐ Front ☐ Rear ☐ Side
Where was the other vehicle impacted ☐ Front ☐ Rear ☐ Side

Auto Insurance Information

Your Auto Insurance:_____ **Policy Number:**_____
Claim Number:_____

Others Auto Insurance:_____ **Policy Number:**_____
Claim Number:_____

General Accident Information

Date of Accident:_____ Time:_____

Describe_____

_____

_____

Before the Accident:

Have you ever had similar symptoms that you are experiencing sense the accident? ☐ No ☐ Yes

If YES, summarize the symptoms:_____

_____

At the Time of the Accident:

When did the pain come on? _____

Were you taken anywhere after the accident?_____

How:_____

Treatment:_____

Since the Accident:

Are your symptoms ☐ Improving ☐ Getting Worse ☐ Same

Any activities restricted due to the accident?_____

Attorney Name:_____ **Attorney Cell:**_____