REACTIVATE Chiropractic & Rehab

Motor Vehicle Collision / Personal Injury Questionnaire

Name:

Last Name	First Name	Middle Name or Initial	Date of Birth

Attorney Info (If you have a legal representation)
Law firm: _____
Lawyer: _____
Address: _____
_____
Phone: _____
Fax: _____

Your Vehicle Info (Vehicle you were in)
Please supply all info possible. If unknown, leave blank.
Make: _____ Year: _____
Model:_____ Color: _____

Insurance Company: _____
Policy # _____
Claim # _____
Adjuster Name _____
Adjuster Phone _____
Adjuster Fax _____

Med Pay Available? $_____
Process for Billing Med Pay _____
_____
_____
_____

Other Vehicle Info (Other vehicle in accident)
Please supply all info possible. If unknown, leave blank.
Make: _____ Year: _____
Model:_____ Color: _____

Insured Name: _____
Insurance Company: _____
Policy # _____
Claim # _____
Adjuster Name _____
Adjuster Phone _____
Adjuster Fax _____
Have they admitted fault/responsibility for the accident? Yes No Unknown

Additional Info (If Third Vehicle or Insurer involved)
Make: _____ Year: _____
Model:_____ Color: _____
Insured Name: _____
Insurance Company: _____
Policy # _____
Claim # _____
Adjuster Name _____
Adjuster Phone _____
Adjuster Fax _____

Collision Information

Date of your Collision: _____ Time of Collision _____
Location of Collision(City or area and State):_____
Your vehicle: □was struck by the other □struck the other vehicle □Both □Neither □Unknown
The initial impact to your vehicle was: □Front □Rear □Left Side □Right Side □Unknown
Was your vehicle shoved: □Forward □Backwards □Sideways □Unknown
Did your vehicle: □Spin □Roll □Flip □Slide □None of these □Unknown
Did the vehicle strike another vehicle or object after initial Impact: □Yes □No
If Yes, please explain: _____
_____
Speed at impact: Your vehicle_____mph Other vehicle_____mph
Road Conditions at the time of collision: □Dry □Wet □Sand □Mud □Ice □Snow
Your vehicle was in: □Park □Neutral □Gear □Moving □Stopped
Brakes were: □Applied □Not Applied □Emergency Brake Set □NA
How much Damage was done to the outside of the car: □None □Some □A lot □Totaled
Describe:_____
How much Damage was done to the inside of the car: □None □Some □A lot □Totaled
Describe:_____

Bodily Damage Information

Your position in the vehicle: □Driver □Front Passenger □Back Driver-side □Back Passenger-side
□Center □Pedestrian □Other_____

Your Body was shoved: □Forward □Backwards □Sideways □Unknown

Were you surprised by the impact: □Yes □No □Other _____

Did you have to be extracted from the car: □Yes □No

Please explain:_____

Were you wearing a seatbelt at collision: □Lap Belt □Shoulder Belt □Harness □Child Seat □Not wearing

Did the seatbelt cause damage to your body: □Yes □No □Unknown

Did you brace your arms against: □Dash □Steering Wheel □Seat □Other_____

Did you brace your legs against: □Dash □Floor □Breaks □Seat □Other_____

Did part(s) of your body strike a part of the car: □Yes □No

If Yes, Explain: _____

_____

_____

_____

Which way were you looking during impact: □Straight □Left □Right □Down □Up

Did you lose consciousness/how long: □Did not lose consciousness □Yes_____

Did you feel pain immediately after the impact: □Yes □No

Describe areas of pain: _____

_____

Did you feel Pain sometime after the accident: □Yes □No

Please Explain: _____

_____

Did you go to the hospital: □By ambulance □Drove to hospital □Driven to hospital □Did not go to hospital

If hospital visit, when: □NA □Right after accident □Next day □Other _____

What happened at the hospital (X-rays, diagnosis, meds, brace, advice): _____

_____

_____

Additional Information

Describe any more relevant information about the accident you wish us to know:

_____

_____

_____

_____

_____

Attestation & Signature

Signing below affirms that information given is true and complete to the best of your knowledge.

_____ _____ _____

Patient/Guardian Name Signature Date

Relationship to Patient: □Self □Parent □Guardian □Other _____