COATES
CHIROPRACTIC

Name:_____ **Address:**_____
City:_____ **State:**_____ **Zip Code:**_____
Primary Phone Number:_____ **Secondary Phone Number:** _____
Date of Birth:_____ **Who referred you to our office?:**_____
Email:_____ **Height:**_____ **Weight:**_____

Your Auto Insurance Co.:_____ **Claim #:**_____
Name of Your Adjuster:_____ **Phone Number:**_____
Does Your Policy Have Personal Injury Protection (PIP)? (Circle One): (YES) (NO)
Other Driver's Auto Insurance:_____ **Claim #:**_____
Name of the Adjuster:_____ **Phone Number:**_____

Have you retained an attorney? (Circle One): (YES) (NO) **Name:**_____

Were there any witnesses? (Circle One): (YES) (NO) **Name:**_____

Were the police notified? (Circle One): (YES) (NO) **Investigated By:**_____

Did the police arrive on scene? (Circle One): (YES) (NO)

Was your car towed (Circle One): (YES) (NO)

Nature of Accident

1) **Date of the Accident:**_____ **Time of Day:**_____ (AM) (PM)
2) **Were you:** _____DRIVER _____PASSENGER _____BACK SEAT
3) **Number of People in Your Vehicle**:_____ **Other Vehicle:**_____
4) **Road Conditions:** _____WET _____DRY _____ICY _____OTHER
   Road Surface: _____ASPHALT _____GRAVEL _____DIRT _____OTHER
5) **What direction were you headed? (Circle One):** (NORTH) (SOUTH) (EAST) (WEST)
   Name of the Street:_____
6) **Direction the other car was traveling (Circle One):** (NORTH) (SOUTH) (EAST) (WEST)
   Name of the Street:_____
7) **Were you struck from (Circle One):** (BEHIND) (FRONT) (PASSENGER SIDE) (DRIVER'S SIDE)
8) **Were you wearing a seatbelt? (Circle One):** (YES) (NO)
   If yes, were you wearing a (Circle One): (LAP BELT) (SHOULDER BELT)
9) **Was the airbag activated? (Circle One):** (Yes) (NO)

Did your body make contact with the interior of the car or with an object in the car? (Circle One): (YES) (NO)

If yes, what object or part of the car did you make contact with? _____

_____

What part of your body made contact?: _____

_____

10) **Were you knocked unconscious? (Circle One):** (YES) (NO) **If yes, how long?:**_____
11) **Position At Time of Impact (Circle One):** (Facing Forward) (Looking Down)
Head Turned?: (Left) (Right)
12) **Does your car have a headrest (Circle One):** (YES) (NO)
If yes, about how far was the headrest from the top of your head: _____ inches
Is you head above or below the top of the headrest? (Circle One): (ABOVE) (BELOW)
13) **Were you aware of the approaching impact? (Circle One):** (YES) (NO)
If yes, did you brace for impact? (Circle One): (YES) (NO)
If yes, how did you brace for impact?: _____
14) **Was your car stopped during the impact? (Circle one):** (YES) (NO)
If yes, and if you were the were the driver, was your foot on the brake pedal?
(Circle One): (YES) (NO)
If no, were you: _____Gaining Speed _____Slowing Down _____Traveling at a Steady Speed
15) **What was your approximate speed _____miles per hour.**
16) **Did your vehicle hit a second car? (Circle One):** (YES) (NO)
Another object? Please describe: _____
17) **Was the other vehicle moving at the time of the collision? (Circle One):** (YES) (NO)
If yes, was the other vehicle:
_____Gaining Speed _____Slowing Down _____Traveling at a Steady Speed
18) **What type/make & model of car were you driving?:** _____
What type/make &model was the car that impacted you?: _____
19) **How did you leave the scene?:** _____
20) **In your own words, please describe the accident, including what you heard, saw, and felt**: ___
_____
_____
_____
_____
_____
_____
21) **Estimated cost of damage to your vehicle:** _____.
Do you have photos that show the damage? (Circle One): (YES) (NO)
22) **CIRCLE all that apply. Which parts of the car were damaged during the accident:**

Windshield
R/L Side of Vehicle
R/L Front Quarter Panel
R/L Rear Quarter Panel
Front Bumper

Rear Bumper
Other: _____

23) **Did you receive emergency care IMMEDIATELY following the accident?**
(Circle One): (YES) (NO)
If yes, where did you receive care, type of treatment, and doctor's name: _____
_____
_____

24) **Have you been treated by another doctor since the accident? (Circle One):** (YES) (NO)
If yes, list the doctors name and treatment given: _____
_____
_____

25) **Can you describe what type of pain you are experiencing (i.e. dull, sharp, stabbing, aching, etc.)?:** _____
_____

26) **What activities have become difficult for you in your normal routine? And is the a time limit or number of repetitions before your symptoms are aggravated?:** _____
_____
_____

27) **Since the injury occurred, are the symptoms (Circle One):**
(IMPROVING) (STAYING THE SAME) (GETTING WORSE)

28) **Did you have any physical complaints BEFORE THE ACCIDENT? (Circle One): (YES) (NO)**
If yes, please describe: _____
_____
_____

29) **Do you have any congenital (from birth) factor which relates to this (or these) physical complaints?**: _____
_____

30) **Have you ever been in an auto accident before? (Circle One):** (YES) (NO)
If yes, please describe and include dates and injuries: _____
_____
_____

31) **CIRCLE SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT (Please specify Right or Left if it applies):**

Headache	Knee/Foot Pain	Face Flushing
Neck Pain	Shoulder Pain	Loss of Taste
Neck Stiffness	Elbow Pain	Loss of Memory
Upper Back Pain	Wrist Pain	Loss of Smell
Middle Back Pain	Arm Pain	Cold Sweats
Lower Back Pain	Leg Pain	Dizziness
Hip Pain	Chest Pain	Fainting

Fever	Sleeping Problems	Pins/Needles in Toes
Ringing in Ears	Head Seems Heavy	Shortness of Breath
Irritability	Pins/Needles in Arms	Light Bothers Eyes
Fatigue	Pins/Needles in Legs	Cold Hands/Feet
Diarrhea	Pins/Needles in	
Depression	Fingers	

Symptoms other than above: _____

_____

32) **Employer:** _____

Type of Work: _____

33) **Have you lost time from work as a result of this accident? (Circle One):** (YES) (NO)
If yes, dates you have been off of work: from _____ **to** _____
Are you being compensated for lost time? (Circle One): (YES) (NO)
Is it considered Medical Release? (Circle One): (YES) (NO)

34) **Please list any additional information not covered that you feel is pertinent to this accident:**

_____

_____

35) **Is there a possibility that you may be pregnant? (Circle One)**: (YES) (NO)

_____ The above information is true and correct to the best of my knowledge. I accept and acknowledge ultimate responsibility for all charges that I incur in this office.

_____ I also acknowledge that payment for any service I receive is not contingent on any settlement, judgement, or verdict by which I may eventually recover damages.

_____ I hereby authorize Coates Chiropractic to release to my insurance carrier any information required for my claim.

_____ _____

Patient Signature **Date**