Kenmore CHIROPRACTIC

COLLISION INFORMATION

Name:_____ **Date:**_____ **Drivers License #:**_____
Date of Accident: _____ **Time of Accident:** _____**(am/pm) City:** _____
Street/Intersection: _____ **Direction headed?** North/South/East/West**? Car ended facing the same direction?** YES/ NO **Year, Make, and Model of vehicle you were in:** _____
Road Conditions: Wet, Dry, Icy, Other_____ **Were you:** Driver, Passenger (Front/Back), Pedestrian
Did another vehicle(s) strike you? YES or NO **Did you strike other vehicle(s)?** YES or NO.
Were you struck from: Behind, Front, Left, Right? **Were you:** Accelerating, Slowing Down or Stopped
If stopped, was the driver's foot on the brake? YES/ NO **If moving, estimate how fast:** _____mph
Were you aware of the approaching collision? YES/ NO **Did you lose consciousness on impact?** YES/ NO
Was the top of your head Above, Even, Below **the top of the headrest? If above/below _____ inches**
Were you wearing a seatbelt? Lap, Shoulder/Lap, No **Were you looking straight ahead?** YES or NO
If No, were you looking RIGHT or LEFT**, with** HEAD or BODY? **How far?**_____
Circle any of your body parts that hit the interior of your car during impact: Head, Face, Chest, Shoulder (right/left), Arm/Wrist (right/left), Hip (right/left), Leg/Knee (right/left), Other:_____
Did you find any Bruises? YES or NO **If Yes, where?** _____
Did you find any bleeding cut? YES or NO **If Yes, where?** _____
Did the police come to the scene? YES/ NO **Were traffic citations issued?** To Driver, To other Driver, No
Cost of the damage to the vehicle you were in? _____
Circle any of the following car parts damaged during accident: Windshield, Steering Wheel, Seatbacks, Rear Bumper, Front Bumper, Side Windows (Left OR Right, Front OR Back), Back Windshield

INSURANCE INFO

Your Insurance Company: _____ **Claim Number:** _____
Adjuster's Name: _____ **Phone:** ( ) - **Fax:** ( ) -
Have you reported this accident to your Insurance Co? YES or NO **Do you have PIP coverage?** YES or NO
Have you chosen an attorney yet? YES or NO **If yes, Name:** _____ **Phone#:** ( ) -
Other Driver's Name?
Other Driver's Insurance Company: _____ **Claim Number:** _____
Adjuster's Name: _____ **Phone:** ( ) - **Fax:** ( ) -

We need a copy of the Incident Report from the Police AND a copy of your personal Health Ins. Card