

The Back Clinic

AUTO ACCIDENT REPORT

Full Name: _____ Soc. Sec. No: _____
Address: _____
Home Phone No: _____ Work Phone No: _____
Auto Ins. Co: _____ Policy / Claim No: _____
Address _____
Adjustor: _____ Telephone No: _____
Are there any other insurance companies that may be involved in this accident? []yes []no
If yes, what company and the address: _____

Accident Details

Date of accident: _____ Time: _____ Location: _____

Describe how the accident happened: _____

Was your seat-belt on? []yes []no

Were you driving the care? []yes []no If no, where were you sitting? _____

What was the position of your body and head at the moment of impact? _____

Were you knocked unconscious? []yes []no

Describe your symptoms immediately after the accident _____

Describe you present symptoms: _____

Have you been treated by another doctor? []yes []no If yes, who and the address: _____

Have you been hospitalized? []yes []no If yes, where, when and what was the treatment? _____

Have you been x-rayed? []yes []no If yes, what part(s) of your body and when? _____

At the time of the accident, were you in the course of your employment? []yes []no

Did you lose income because of the accident? []yes []no

Have you been disabled from the accident? []yes []no If yes, dates of disability _____

Draw below how the accident happened