BALANCE POINT CHIROPRACTIC

MOTOR VEHICLE COLLISION FORM

ABOUT YOU

NAME	TODAY'S DATE

ACCIDENT INFORMATION

DATE OF ACCIDENT	TIME OF ACCIDENT	NUMBER OF VEHICLES INVOLVED:

ESTIMATED COST OF DAMAGE TO YOUR VEHICLE: $	LOCATION OF ACCIDENT (ROAD AND CITY)

DIRECTION YOU WERE TRAVELING ☐ NW ☐ N ☐ NE ☐ W ☐ E ☐ SW ☐ S ☐ SE

PRIMARY TYPE OF IMPACT: ☐My vehicle was rear ended ☐My vehicle hit another vehicle from behind ☐My car was hit on the passenger's side ☐My car was hit on the driver's side ☐Other:

WHERE WERE YOU SITTING IN THE VEHICLE? ☐ Driver ☐ Front Passenger ☐ Rear Passenger ☐ Other:

DID YOU KNOW THE ACCIDENT WAS COMING? ☐ Yes, & I braced for the accident ☐ Yeas, but I relaxed ☐ No

TYPE OF VEHICLE YOU WERE IN?	TYPE OF OTHER VEHICLE(S) INVOLVED?

AT THE TIME OF IMPACT, YOUR VEHICLE WAS: ☐Slowing Down ☐Speeding Up ☐Stopped ☐Driving at a Steady Speed

AT THE TIME OF IMPACT, THE OTHER VEHICLE WAS ☐Slowing Down ☐Speeding Up ☐Stopped ☐Driving at a Steady Speed ☐Unknown

DURING AND AFTER THE CRASH, WHAT HAPPENED TO YOUR VEHICLE?	DID YOU LOSE CONSCIOUSNESS DURING THE ACCIDENT? ☐ NO ☐ YES, For how long?

HOW WAS YOUR BODY POSITIONED DURING THE ACCIDENT?	DID ANY PART OF YOUR BODY STRIKE ANYTHING IN THE VEHICLE? ☐ NO ☐ YES, please describe:

WERE YOU WEARING YOUR SEATBELT? ☐NO ☐YES	DID THE AIRBAGS INFLATE? ☐NO ☐YES ☐Not Applicable
WERE THE POLICE NOTIFIED ☐NO ☐YES	WAS A POLICE REPORT FILED? ☐NO ☐YES

IN YOUR OWN WORDS, PLEASE DESCRIBE THE ACCIDENT:

AFTER THE ACCIDENT

WHERE DID YOU GO IMMEDIATELY AFTER THE ACCIDENT? ☐Hospital ☐ Medical Doctor ☐Chiropractor ☐Home ☐Work

HOW DID YOU GET THERE? ☐Drove myself in my vehicle ☐Was driven ☐Ambulance ☐Other:

WHO ELSE HAVE YOU SEEN FOR THIS ACCIDENT? ☐No one ☐Other Chiropractor ☐Medical Doctor ☐Physical therapist ☐Massage therapist

PLEASE LIST TREATMENTS AND PRESCRIPTIONS YOU HAVE RECEIVED:

ADVANCED IMAGING (please select all that apply): ☐None ☐X-ray ☐MRI

AREA: ☐Skull ☐Neck ☐Mid-Back ☐Lower Back ☐Foot ☐Arm ☐Pelvis ☐Hips ☐Leg ☐Knee ☐Shoulder

HAVE YOU BEEN ABLE TO WORK SINCE THIS INJURY? ☐NO ☐YES	HAVE WORK ACTIVITIES BEEN RESTRICTED? ☐NO ☐YES

Location of Problem(s) – PLEASE SELECT ALL THE APPLY

☐ Headaches	☐ Shoulder	☐ Hand	☐ Legs
☐ Jaw	☐ Arm	☐ Mid back	☐ Knee
☐ Neck	☐ Elbow	☐ Low back	☐ Ankle
☐ Upper back	☐ Wrist	☐ Hip	☐ Foot

☐ Other:

IS THE CONDITION GETTING WORSE? ☐NO ☐YES ☐Constant ☐Comes & goes

WHAT MAKES THE PAIN BETTER?

WHAT MAKES THE PAIN WORSE?

ACTIVITIES & RECOVERY

Pain during activities

Activity	Comfortable	Uncomfortable	Painful
Lying on back	☐	☐	☐
Lying on side	☐	☐	☐
Lying on stomach	☐	☐	☐
Sitting	☐	☐	☐
Standing	☐	☐	☐
Stretching	☐	☐	☐
Walking	☐	☐	☐
Running	☐	☐	☐
Sports	☐	☐	☐
Working	☐	☐	☐
Lifting	☐	☐	☐
Bending	☐	☐	☐
Kneeling	☐	☐	☐
Pulling	☐	☐	☐
Reaching	☐	☐	☐

Work Recovery

HOW MANY HOURS DO YOU NORMALLY WORK PER DAY?

PLEASE INDICATE YOUR DAILY WORK DUTIES (Select all that apply)

☐ Standing ☐ Sitting ☐ Walking ☐ Lifting ☐ Driving

☐ Crawling ☐ Bending ☐ Typing ☐ Stooping ☐ Twisting

☐ Operating Equipment ☐ Working with arms above head

☐ Other:_____

Prior to this injury, were you able to work on an equal basis with others your age?

☐ NO ☐ YES ☐ Not Applicable

Do you work with others that can help you with heavy lifting?

☐ NO ☐ YES ☐ Not Applicable

Do you feel you are able to perform your normal work duties at this time?

☐ NO ☐ YES ☐ Not Applicable

Is there "Light Duty" work that you can request?

☐ NO ☐ YES ☐ Not Applicable

INSURANCE

Insurance & Attorney

DO YOU HAVE AN ATTORNEY? ☐ NO ☐ YES Name:	PHONE NUMBER:
TYPE OF INSURANCE	COMPANY NAME:
INSURED'S NAME:	PHONE#
ADDRESS:	
POLICY#:	CLAIM#
INSURED'S EMPLOYER	AGENT'S NAME

Signature

- If any of your medical or account information has changed, please inform our front desk personnel.
- Please remember, you are ultimately responsible for your account.

SIGNATURE:	DATE