Maxeiner Chiropractic and Muscle Therapy Clinic LLC

5791 Zarley St, Suite B New Albany, OH 43054

(614) 600-2225 (p) ~ (614) 245-8888 (f)

AUTOMOBILE ACCIDENT HISTORY

Insurance Company_____ Policy Number_____

Address: _____Name of Agent_____ Phone_____

(Circle all that apply)

Have you retained an attorney? **Yes No**

Name and Address of Attorney:_____

General Symptoms:

Did you hit part of your body during the collision, for example: head on dash, chest on steering wheel? **Yes No**

If yes, which part and how? _____

Where were you taken after the accident? _____

Were you hospitalized? **Yes No** If yes, for how long? _____

Accident History:

Date of Accident: _____ Time of Accident: _____ A.M. P.M.

State how the Accident happened in your own words:

_____

_____

What type of vehicle were you in? Make: _____Year: _____

Were you driving? **Yes No** Was it your car? **Yes No** If not, whose? _____

Passenger? **Front Back Right Side Left Side** Were you rotated in seat? **Yes No**

Were you reclined? **Yes No** Other: _____

Other people in car? **Yes No**

Names and Addresses:

_____

_____

Were they injured? **Yes No**

If yes, please explain: _____

_____

Seat belts on? **Yes No** Shoulder harness on? **Yes No** Position of headrest _____

Was it? **Daylight Night Dark Dawn** What were the weather conditions? _____

How long had you been in the car? _____ What were you doing prior to the Accident? _____

What were the traffic conditions? _____ What was the posted speed limit? _____

How fast were you going? _____ Type of road: **2 Lane** **4 Lane** **Gravel** **Tar**

Did it happen at a/an: **Stop Sign** **Traffic Light** **Intersection** **Highway**

Was your car hit? **Front** **Back** **Left Side** **Right Side**

What damage was done to your car?

Inside: _____

Outside: _____

Other: _____

If you struck another car, did you strike it: **Front** **Back** **Side**

What was the damage to the other car?

Inside: _____

Outside: _____

In what condition was the vehicle prior to the Accident? _____

Do you have pictures of the involved automobile? **Yes** **No**

What type of vehicle was involved in the accident?

Car **Truck** **Motorcycle** **SUV** **Other:** _____ **Size and Type**: _____

Was accident report made? **Yes** **No** Police of: **City: _____ County: _____ State: _____**

Who was ticketed? _____ For what? _____

Did your vehicle strike anything? **Yes** **No** If yes: **Another Car** **Sign** **Tree**

Other: _____ **Size and Type**: _____

Were you completely conscious after the impact? **Yes** **No** Do you remember the impact? **Yes** **No**

Did your vehicle go off the road? **Yes** **No**

State any strange events that happened during or immediately after the Accident:

_____

_____

Have you had any time loss from work? **Yes** **No** If yes, from _____to _____

Have you ever had to have any outside help? **Yes** **No** What type? _____

The above information is accurate and has been completed to the best of my knowledge:

Patient Signature: _____ Date: _____