Auto Accident Information
River Parkway Chiropractic

Dear Patient: This information is considered confidential. We need this information to understand your condition properly. Please be as neat and accurate as possible in completing this form. Thank you!

Name:_____**DOB:**_____**Address:**_____

Insurance Co:_____**Policy#**_____**Claim#**_____
Name Of your Insurance Adjuster:_____
Driver of Other Vehicle (If applicable)
Name:_____**Insurance Co:**_____**Policy#**_____
Driver of Vehicle you were injured in (If not yourself)
Name:_____**Insurance Co:**_____**Policy#**_____
Attorney Name If Applicable:_____**Phone#**_____

Accident Info:

Please explain in detail how your accident happen:_____
_____
_____
_____
_____
Direction you were heading: N__S__E__W__
Street or Hwy you were on:_____
Other Vehicle's Direction: N__S__E__W__
Street or Hwy other vehicle was on:_____
Were Police notified: Yes__No__ Were you knocked unconscious: Yes__No__
Were you struck from: Behind__Front__Left__Right__
Were you: Driver__Passenger__Front Seat__Back Seat__ Seatbelt: Yes__No__
Date of Accident:_____**Time Of Accident:**_____
Did you feel pain immediately after accident: Yes__No__
Where were you taken after the accident/Or did you go home:_____
_____
Did you see another Doctor for this accident: Yes__No__
If Yes: Name&Address:_____
Have you ever had complaints in the involved area before: Yes__No__
If yes, what was the complaint:_____
_____