CHIROPRACTIC of BELLEVUE
DR. EDWARD OWENS, D.C.
13400 NE 20th St Suite 2
Bellevue, Wa 98005

Personal Injury Information

Name: ______________________________ Date: ____________

Choose One:

____I am the at fault party

____I am not the at fault party

____Not sure

Other party's name__________________ Phone____________________________

Address____

Other Party's Insurance Company____

Claim Number__________________ Anything else?________________________

____

If you have filed a personal injury claim with your insurance, please fill out the following:

Insurance Company____________________ Claim Number______________________

Adjuster name________________________ Phone Number ____________________

Do you have a lawyer that will be helping you with your accident claim?

Name______________________________ Phone__________________________

____I would like to use a lawyer but I do not have one yet.

____I do not want to use a lawyer.

____Describe briefly where the accident occurred (Intersection, address, or whatever you can remember)____

____

If you do not have this information currently, please fill out what you can now and let us know when you have the rest.

PO Box 1238, Bellevue, WA 98009-1238
Tel.: 425-802-5432 Fax: 425-749-7233

Automobile Accident

Date of accident: __________

Vehicle Info

Your Vehicle Type

Car S.U.V. Van Bus
Large Truck Pickup Truck
Other __________________

Your Position in Vehicle

Driver Front Passenger
Left Rear Passenger Right Rear Passenger
Other __________________

Time/Speed/Damage

Time of Accident ________ Your Vehicle's Speed ________ mph
Their Vehicle's Speed ________ mph

Damage to your Vehicle

Mild Moderate
Totaled

What was your vehicle doing at the time of the accident?

Stopped at intersection Stopped in traffic Stopped at light
Making a right turn Making a left turn Parking
Proceeding along Slowing down Accelerating

Other ____

Details of Accident

Visibility at the time

Good Fair Poor

Road Conditions at Time of Accident

icy wet sandy dark clean and dry

Point of Impact

Head-On Rear-End
Left front Right front
Left rear Right rear

Who hit who/what?

You hit other vehicle
Other vehicle hit you
You hit _____________

Additional Accident Information

Include any additional information here that is not covered by the above check offs:

During the Accident

Body Position, etc.

			Headrest Position?
Did you see the accident coming?	Yes	No	Even with top of head
Were you braced for the impact?	Yes	No	Even with bottom of head
Did you have a seat belt on?	Yes	No	Even with the Middle of the neck
Did you have a shoulder harness on?	Yes	No	
Did the driver's forward air bag deploy?	Yes	No	
Did passenger's forward air bag deploy?	Yes	No	
Did the side air bags deploy?	Yes	No	
Does your vehicle have headrests?	Yes	No	

What was the direction of the head at the time of impact?

Facing straight forward   Turned to the right   Turned to the left

Did your body strike the inside of your vehicle? Yes No

If yes, describe ______________________________

Did you lose consciousness during the injury? Yes No

If yes, for how long? ________________

Your vehicle's estimated damage: ________

Damage to their vehicle?

Mild   Moderate   Totaled

Did the police show up at the scene?

Yes No

Was an accident report filled out?

Yes No

Post-Accident Treatment

Where did you go after the accident?

Home   Work
Hospital ER   Private doctor

How did you get there?

Drove Self   Ambulance
Somebody else   Police

X-rays done? Yes No

Body parts X-rayed? ________________

Any lab work? ________________

The x-rays revealed… ______________________________

Treatments: Cervical Collar   Ice   Other: ________________

Medications: ______________________________

Follow-up instructions: ______________________________

After the Accident

Check off the symptoms right after and a few days following accident

Headache	Loss of smell	Tension	Loss of Taste	Diarrhea
Neck Pain	Dizziness	Irritability	Toe Numbness	Depression
Neck stiffness	Nausea	Mid back pain	Constipation	Anxious
Fainting	Confusion	Low back pain	Cold hands	Chest pain
Ringing in ears	Fatigue	Nervousness	Cold feet	
Pain behind eyes	Shortness of breath		Sleeping Problems	

Other: ______________________________

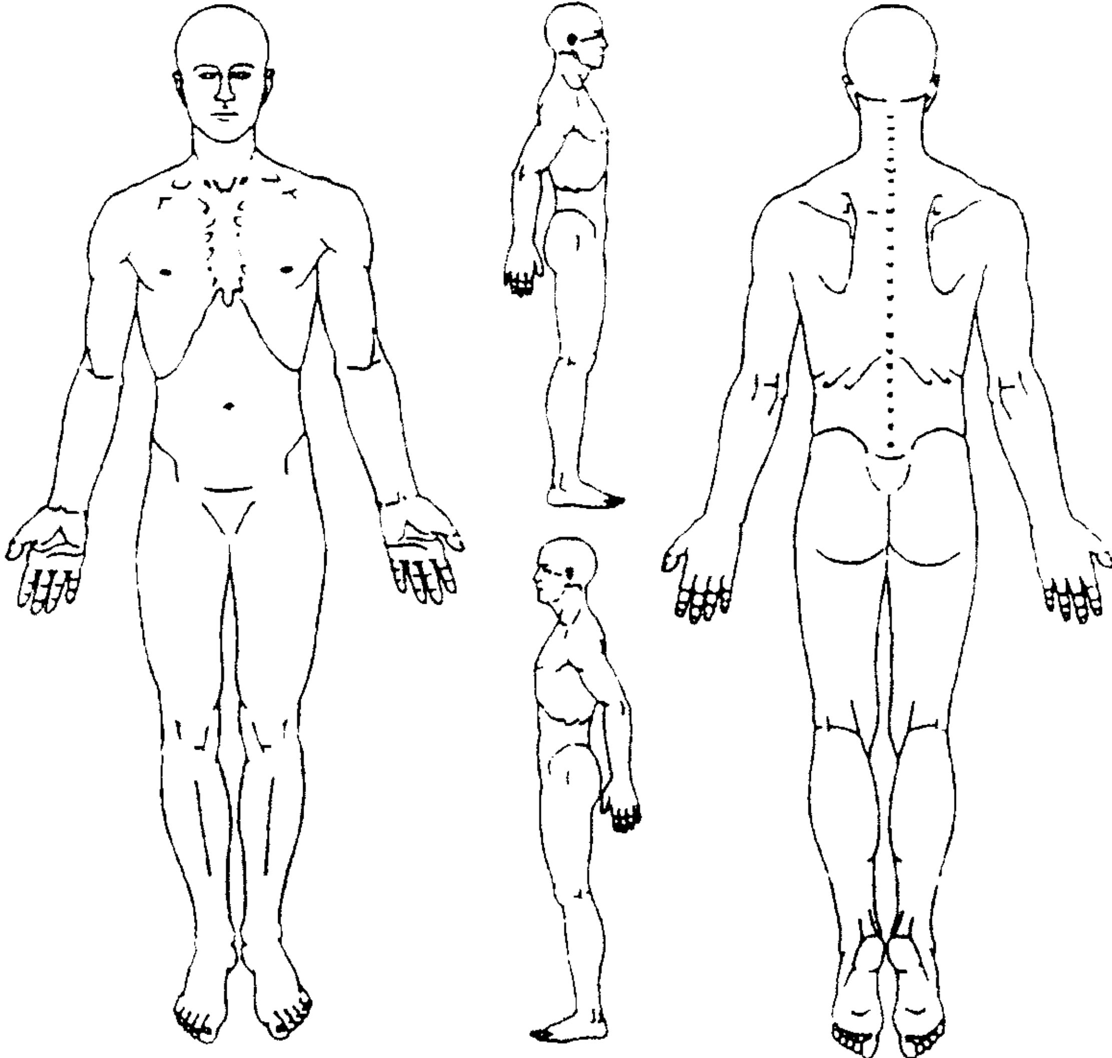
PAIN DRAWING

PATIENT NAME ______________________________ DATE ____________

On a scale from 0 – 10, with 10 being unbearable pain, how severe is your pain?

PAIN INTENSITY	None	MILD			MODERATE				SEVERE		
PAIN LEVEL	0	1	2	3	4	5	6	7	8	9	10

ON DRAWING BELOW, CIRCLE AND USE THESE LETTERS TO INDICATE TYPE AND LOCATION OF DISCOMFORT:				
D = DULL	SH = SHARP	A = ACHING	C = CUTTING	CR = CRAMPING
TH = THROBBING	B = BURNING	N = NUMBING	TI = TINGLING	CO = CONSTRICTING
SP = SPASM	ST = STINGING	S = SHOOTING	P = POUNDING	T = TIGHT



DOCTOR USE ONLY:

COMPLAINT	T%: 0 – 25	26 – 50	51 – 75	76 – 100