Warner Family Chiropractic
6630 W. Cactus #B106
Glendale, AZ 85304
(623) 486-2000 Fax (623) 486-2041

Name: _____
Address: _____
City/State/Zip: _____

Date of accident: _____
Time of accident: _____
Who was found to be responsible for this accident: _____
Was your insurance company notified: YES NO
Was the other driver's insurance company notified: YES NO DON'T KNOW

Your auto insurance company information
Company name: _____
Address: _____
City/State/Zip: _____
Phone #: _____
Claims adjuster's name: _____
Policy holder's name: _____
Policy #: _____
Type of Policy: MEDPAY Liability
Claim #: _____

Other driver's auto insurance company information
Company name: _____
Address: _____
City/State/Zip: _____
Phone #: _____
Claims adjuster's name: _____
Policy holder's name: _____
Policy #: _____
Claim #: _____

Attorney's Name and Phone # (if one has been retained):
_____

Please describe what happened in the accident:
_____
_____
_____

Patient Vehicle Information
Where were you in the vehicle: _____
What type of vehicle were you in: _____
What was the speed of your vehicle: _____
What was your vehicle doing immediately prior to impact(i.e.- changing lanes, proceeding through a green light, etc.):
_____
Was your vehicle accelerating: YES NO
What direction was your vehicle heading: _____
On what street: _____
What was your vehicle's point of impact: _____
What was the amount of damage to your vehicle: _____
What was the road condition: Dry Wet Slick Icy Gravel Pavement Other

What was the visibility: _____

Other Vehicle Information
Was there another vehicle involved: YES NO If yes, what type was it:_____
What was the speed of the other vehicle: _____
What was the other vehicle doing just prior to impact: _____
What was the other vehicle's point of impact: _____
What direction was the other vehicle heading: _____
On what street: _____
Was a police report filed: YES NO If yes, do you have a copy: YES NO

Patient Information
Did your airbags deploy: YES NO
What was the position of the head rests: Normal Low High None
Did you have your seatbelt on: YES NO
Did you have a shoulder harness on: YES NO
Were you prepared for the impact: YES NO
What was the position of your head prior to impact:
_____
Did you contact anything within your vehicle: YES NO If yes, what:
_____
Did you lose consciousness: YES NO
Did you receive emergency care at the scene: YES NO
Where did you go following the accident:
_____
Please describe any other details you feel I should know:
_____
_____
_____
What are your present physical complaints:
_____
_____
_____
Did you have any physical complaints prior to this accident:
_____
How did you feel during the accident(i.e.- pain, tension, fear):
_____
Immediately after the accident, how did you feel:
_____
Later that day:
_____
The Next day:
_____
Please describe your work duties prior to this accident:
_____
Have you returned to work since the accident: YES NO
Date last worked: ___/___/___
Have you noticed any social, sporting, or emotional limitations since the accident:
_____
Have you been treated by another doctor for this injury: YES NO

_____ _____
Patient's/Guardian's signature Date