Scituate Harbor Chiropractic

Automotive Accident Form
(side one)

76A Front Street, Suite 21, Scituate, Massachusetts 02066

(781) 545-7388 • (781) 545-6552 fax

Please take a moment to complete all the questions regarding your accident.Details are very important and are used in conjunction with the doctor's analysis and final care program.

New Member Information

Full Name ______________________ ❑ Male ❑ Female

What do you prefer to be called? ______________________ Date __________

Age __________ Date of Birth __________ SS# __________

Home Address ______________________

City ______________________ State __________ Zip __________

Home Phone ______________________ Mobile Phone ______________________

eMail Address ______________________

Name of Insured (check here if same as above ❑)

Full Name ______________________ SS# __________

Home Address ______________________ Phone __________

City ______________________ State __________ Zip __________

Auto Insurance

Insurance Carrier ______________________

Policy # ______________________ Claim # ______________________

Address ______________________

City ______________________ State __________ Zip __________

Carrier Phone ______________________ Adjuster's Name (if known) ______________________

Accident Information (history of onset)

Date of Accident __________ Time of Accident __________ ❑ AM ❑ PM

Have you retained an attorney? ❑ Yes ❑ No *If yes, give attorney name and address:*

Attorney Name ______________________ Address ______________________

Please describe in detail of how your accident occurred ______________________

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______________________ *continued next page*

Promoting Health and Well Being Through Chiropractic Care

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accident details continued ______________________________

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Accident Injury Information

What was your position in the vehicle? ______________________________

What type of vehicle were you driving? ______________________________

What was your speed at the time of the accident? ______________________________

Who hit whom? ______________________________

Where was your vehicle's point of impact? ______________________________

What speed was the other vehicle traveling? ______________________________

Where was the other vehicle's point of impact? ______________________________

Were you wearing seat restraints? ______________________________

In what position was your vehicle head rests? ______________________________

Did your air bad deploy? ______________________________

Were you prepared for the impact? ______________________________

In what position was your body just prior to impact? ______________________________

What happened to your body at the moment of impact? ______________________________

What was your mental/emotional state immediately following the accident? ______________________________

____

Did you receive medical attention at the scene of the accident? ❏ Yes ❏ No

Where did you go immediately following the accident? ______________________________

Bodily Injuries

List each body part that struck the following vehicle part during the accident.

Dashboard ______________________________

Windshield ______________________________

Steering Wheel ______________________________

Right Door ______________________________

Left Door ______________________________

Seat Frame ______________________________

Unknown Object ______________________________

Promoting Health and Well Being Through Chiropractic Care

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Member Name (please print) Member Signature Date