Place patient sticker here

Auto Incident Report

POLAR FAMILY
CHIROPRACTIC CENTER
2470 McKnight Rd N, North St. Paul, MN 55109 (651) 777-3877

Date:_____

1a Motor Vehicle Collision Information

Date of accident ___/___/_____ Time _____ AM PM

Location of incident_____

Briefly describe how the incident occurred: _____

_____

_____

_____

You were the: ○Driver ○Front Passenger ○Rear Passenger ○Pedestrian

Were you wearing a seat belt? ○Yes ○No

Where were you looking at the time of impact?
○up ○down ○left ○right ○forward ○behind

Were you rotated in the seat at impact? ○Yes ○No _____

Did any part of your body strike anything inside your vehicle?

_____

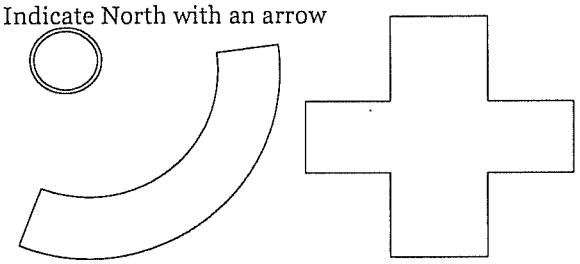
Was your vehicle equipped with air bags? ○Yes ○No
If yes, did the air bags deploy? ○Yes ○No

Were you ○aware or ○surprised by the impact?

Did you lose consciousness at any time following the collision?
○Yes ○No _____

1b FOR OFFICE USE ONLY

Indicate North with an arrow



Patient's vehicle = 1 Other involved vehicles = 2,3,4.....

Was a police report made? ○Yes ○No

Direction of your travel? _____ other vehicle _____

Were you struck from: ○behind ○right side ○front ○left side

Was anyone else in the vehicle? ○Yes ○No
If yes, whom_____

Location of hands at time of impact: Right _____ Left_____

Location of feet at time of impact: Right _____ Left_____

Did your vehicle go off the road? ○Yes ○No
If yes, did it strike anything? _____

2 Patient Information

What did you feel immediately after the collision? _____

_____

_____

Where were you taken after the collision? _____

_____

What was done for you?_____

_____

What are you currently having problem with?_____

_____

_____

Have you seen any other physicians for your conditions? ○Yes ○No
Who?_____ Where? _____

If yes, what was done for you?_____

_____

Have you had any similar problems in the past? ○Yes ○No
Describe:_____

_____

Have you missed any work/school since the collision? ○Yes ○No
Dates from _____ to _____

Have you returned to work/school? ○Yes ○No _____

○Full time ○Part time _____

Are you presently unable to perform any social/recreational/household activities that you enjoyed prior to auto collision?

_____

_____

Have you had any previous motor vehicle collisions? ○Yes ○No
Describe:_____

_____

3 Insurance Information

Please present your auto insurance card so we can make a copy for your file

Have you reported this incident to your insurance agent/company? ○Yes ○No

Contact info of whom the incident was reported to: Company _____ Name_____
Phone Number (____) _____-_____

If you have been given a claim number by your insurance company, please enter it here _____