Hadley CHIROPRACTIC

Car Accident Fact Sheet

- **Date of Accident _____ Time _____ A.M. / P.M.**
- **Were you: □ Driver □ Passenger □ Front Seat □ Back Seat**
- **Number of people in your car _____**
- **Were you wearing a seat belt? □ Yes □ No**
- **Was your airbag involved? □ Yes □ No**
- **What direction were you headed (check more than one if appropriate)?**

  □ North □ South □ East □ West

  on (name of street) _____
- **Approximate speed of your car: _____ m.p.h.**

  other car: _____ m.p.h.
- **Were the police notified? □ Yes □ No**
- **Please briefly describe the accident:**

- **Have you seen any other doctors for this accident? □ Yes □ No**

  <u>If yes</u>:

  Whom have you seen?

  What did they do?
- **Are you: □ improved □ unchanged □ getting worse**
- **Prior to the accident, have you had complaints similar to what you now have? □ Yes □ No**
- **Have you lost any time from work as a result of this accident? □ Yes □ No**
- **Information about <u>your</u> automobile insurance company:**

Ins. Co. _____ Phone #: _____

Address _____Claim #: _____

Please note: It is your responsibility to notify your insurance company of this accident and to inform them that you have come to our office for evaluation and care.

Signed _____ Date _____