WAGNER Chiropractic
A Center For Healing

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*If your injury is **Not** due to an Automobile Collision, please skip this portion of the form.*

Please provide staff with a copy of your automobile insurance card and a copy of the police report, if it is available.

Your Name: _____

Insured's/Policy Holder Name(s): _____

Have you contacted your auto insurance company? ☐Yes ☐No ☐n/a (LOP)

*Adjustor's Name: _____ Phone Number: _____ Ext: _____

Fax Number: _____

Claim Number: _____ Policy Number: _____

Were you the ☐Driver ☐Front Passenger ☐Back Left Side Passenger ☐Back Right Side Passenger ☐Pedestrian ☐Other: _____

How many people were in the vehicle? _____

Were you wearing a seatbelt at the time of the accident? ☐Yes ☐No

Was your vehicle stopped? ☐Yes ☐No If no, approximate speed: _____ mph

Was the other vehicle stopped? ☐Yes ☐No If no, approximate speed: _____ mph

At impact, was your body straight in your seat? ☐Yes ☐No If no, was your head turned to the (☐Left / ☐Right ☐Other: _____

At Impact, were you looking straight ahead? Yes No If no, was your head turned to the (☐Left / ☐Right / ☐Up/Down)

Were you aware that you were about to be hit? ☐Yes ☐No Were you struck from: ☐Behind ☐Front ☐Left side ☐Right side

Did your (chest / head) hit the steering wheel? ☐Yes ☐No Did an airbag deploy? ☐Yes ☐No

Did your head hit the (Windshield / Side Window)? ☐Yes ☐No

Did your knees hit the dashboard? ☐Yes ☐No

Did you lose consciousness? ☐Yes ☐No If yes, how long: _____

Did the police arrive at the scene? ☐Yes ☐No

Did you strike the other vehicle? ☐Yes ☐No did the other vehicle strike you? ☐Yes ☐No

Were traffic citations issued to? ☐You ☐ Driver of your car ☐Driver of the other car ☐None

Your car was heading: ☐North ☐South ☐East ☐West on _____ (street or highway)

The other car was heading: ☐North ☐South ☐East ☐West on _____ (street or highway)

_____
*Signature of Patient, Parent, Guardian or Personal Representative