Auto Accident Report

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Name: ______________________ **Date of accident:** ____________________

Please describe or sketch the accident:

Year/make/model of your car: ______________________ **other car:** ______________________

Total # cars involved: ____________ **Est. speed of your car:** ____________ **other car:** ____________

Were you hit from: ☐ Front ☐ Back ☐ Right side ☐ Left side

Were your brakes applied? ☐ yes ☐ no **Was your car:** ☐ automatic ☐ manual transmission

Were you: ☐ driver ☐ passenger **Were you wearing:** ☐ lap belt ☐ shoulder belt

Were you aware of the impending collision? ☐ yes ☐ no **Road conditions were:** ____________

Did you hit anything on the inside of the car? ______________________

Was there more than one impact? ____________ **How many did you feel?** ____________

Were there: ☐ Multiple vehicular impacts ☐ Impacts with road barriers (poles, trees, barriers, etc.)

Were you knocked unconscious or dazed? (circle answer) For how long? ____________

Describe your head position at the time of the impact: ______________________

Did you notice any bruising/swelling? Where? ______________________

Have you been examined/treated since the accident (Hospital ER, Dr., etc): ____________

Was an accident report made? ________ **Est. of auto damage: $** ________ **Was your car drivable?** ________

Have you lost work time as a result of your injuries? ____________ **How much?** ____________

Have you had any previous accidents resulting injury/treatment? ______________________

____

INSURANCE INFORMATION:

Your Health Insurance Co. ______________________

Address: ______________________ **Policy #** ____________

Your Auto Insurance Co. ______________________ **Policy #** ____________

Address: ______________________ **Adjuster:** ____________

Phone #: ______________________ **Have you reported this accident?** ____________

Other Party's Insurance Co. ______________________ **Policy #** ____________

Address: ______________________ **Adjuster:** ____________

Phone #: ______________________ **Have you been contacted?** ____________

Has an attorney advised you in this matter? ____________ **Are you being represented?** ____________

Attorney Name: ______________________ **Phone #** ____________

Address/City/State/Zip ______________________

Information about your current condition/complaints

Bryan Bingham DC
3531 NE 15th Ave Ste. E, Portland, OR 972121
503.546.9987 fax 503.546.9988

What is your primary complaint/problem? ______

List other symptoms: ______

When did your symptoms first begin (give date if possible)? ______

How did your symptoms first begin? ______

Pain is: ☐ Constant ☐ Intermittent **Is your condition getting worse?** ______

What activities aggravate your condition? (list) ______

What activities lessen your symptoms? (list) ______

List *all* Doctors/therapists/specialists seen for this problem & treatment given (use back of page if necessary):

1. ______
2. ______
3. ______

Have you had: ☐ Xray ☐ MRI or CAT Scan ☐ EMG ☐ Bone Scan ☐ Blood Work

Who is your family medical doctor: ______

List all home remedies tried for this problem: ______

Is your condition worse at certain times of the day or night? ______

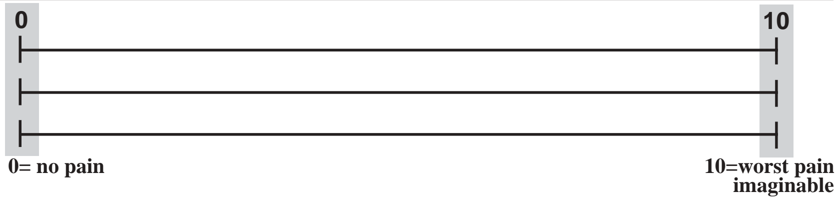
Does your condition interfere with: (yes/no) work ______ sleep ______ normal daily routine ______

Have you had symptoms like this before? ☐ no ☐ yes (describe) ______

Regarding your main complaint:

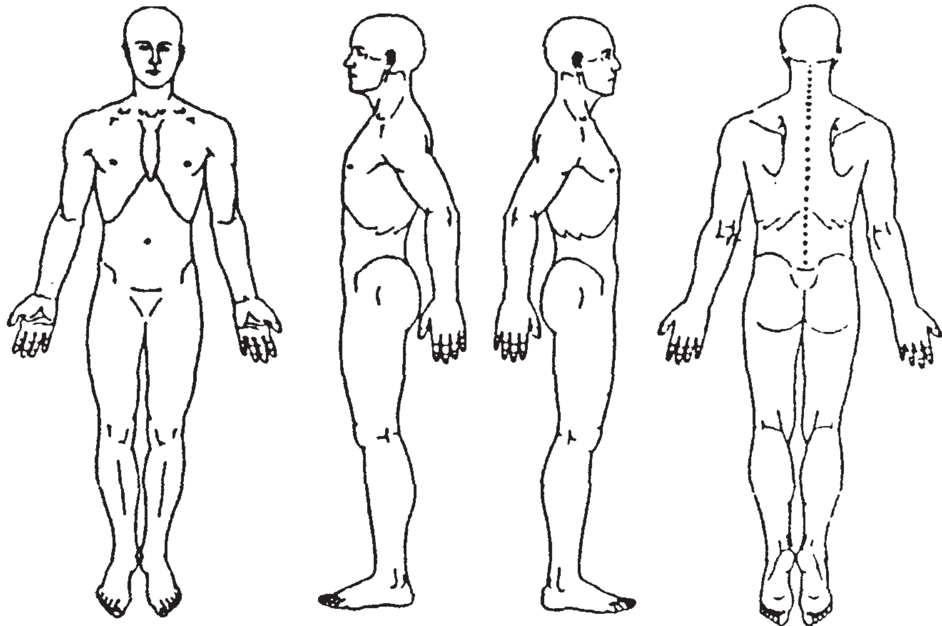
How bad is your pain?
(make a slash on all 3 scales)

1. RIGHT NOW:
2. AVERAGE:
3. AT WORST:



Draw the area of your symptoms using these symbols:
(mark on the figures)

XXX = ache
*** = sharp/stab**
ooo = numb/tingle
⟶ = shooting
/ / / / = stiff/tight



Pt. History 3.1
#1.04 SCSI©

NOTICE TO NEW PATIENTS: **Payment in full for chiropractic services rendered is due in full at the end of each visit. If for any reason this request cannot be met, arrangements must be made in advance before seeing the physician. We value and protect your privacy. I grant permission to the Dr. to use the information in my medical record to assist in the clinical improvement process.**

Patient Signature: ______ **Date** ______