Bidwell CHIROPRACTIC

Patient's Name: _____
Date: _____

New PIP Patient Form

What was the date of the accident? _____

What time did the accident occur? _____

Do you have an attorney? □ No □ Yes If yes, please provide the following information:

Name _____ Phone number_____

Address _____

How many vehicles were involved? _____

Did you miss any work? If yes, how long _____

Where you the driver of the car? □ No □ Yes If not, where were you sitting? _____

Who else was in the car? _____

What was the estimated damage to the vehicle you were in? _____

What was damaged in your vehicle? (circle all that apply)

- Completely totaled
- Nothing
- Dashboard
- Bumper (front/rear)
- Windshield
- Mirror
- Trunk
- Steering wheel
- Window (side/rear)
- Door (front/back/left/right)
- Other: _____

Were any items dented inward was a result of the accident? □ No □ Yes

If yes, which? _____

Were any of the doors unable to open as a result of the accident? □ No □ Yes

If yes, which?_____

What city and state did the accident occur in? _____

What street or intersection were you on when the accident occurred? _____

What type of impact was the accident? _____

Did you know the accident was coming? □ No □ Yes and I relaxed □ Yes and I braced myself

What type of vehicle were you in? _____

What type of vehicle hit yours? _____

Did you have your seatbelt on during the accident? □ No □ Yes

Did you slide out of your seatbelt during the accident? □ No □ Yes □ Partially

Did you lose consciousness during the accident? □ No □ Yes

At the time of the impact, how fast was your vehicle moving? _____

Your vehicle was: □ Stopped □ Slowing down □ Maintaining speed □ Speeding up

At the time of impact, how fast was the other vehicle moving? _____

The other vehicle was: □ Stopped □ Slowing down □ Maintaining speed □ Speeding up

During and after the crash what happened to your vehicle? (circle all that apply)

- Kept going straight
- Kept going straight hitting a car in front
- Was hit by another vehicle
- Other _____
- Spun around
- Spun around and hit a stationary object
- Hit a stationary object

What kind of headrest was in your vehicle?

□ Movable fixed headrest □ Nonmovable fixed headrest □ No headrest

Where was the headrest positioned on your head? _____

How was your torso positioned during the accident? _____

How was your head positioned during the accident? _____

How were your hands positioned during the accident? _____

Did your head hit anything during the accident? □ No □ Yes, please describe:

_____

Did your face hit anything during the accident? □ No □ Yes, please describe:

_____

Did your shoulders hit anything during the accident? □ No □ Yes, please describe:

_____

Did your neck hit anything during the accident? □ No □ Yes, please describe:

_____

Did your chest hit anything during the accident? □ No □ Yes, please describe:

_____

Did your hips hit anything during the accident? □ No □ Yes, please describe:

_____

Did your knees hit anything during the accident? □ No □ Yes, please describe:

_____

Did your feet hit anything during the accident? □ No □ Yes, please describe:

_____

Did you go to the hospital? If no, skip the following questions.

How did you get to the hospital? _____

What was the name of the hospital? _____

Were you hospitalized over night? □ No □ Yes

Circle what you were prescribed at the hospital:

- Pain medication - Muscle relaxers - Neck brace

- Other: _____

Did you receive any stitches for any cuts at the hospital? □ No □ Yes

Were x rays or other tests done at the hospital? If yes, what were they?

_____

_____

Please list and date the other doctors that have treated you.

_____

Please list and date any diagnostic tests that were performed (i.e. MRI, Cat Scan, EMG, etc.)

_____

_____

Please list and date any previous injuries or accidents.

_____

Are you currently receiving treatment for your injuries? If yes, what treatment(s)?

_____

_____