CASCADIA
HEALTH CARE, P.C.

4916 NE St. Johns Road, Vancouver, WA 98661
(360) 694-4811

Motor Vehicle Accident Information

Date______________________

Patient ____ Claim # ____________________

Patient Auto Insurance Co. ____ Policy # ____________________

Billing address ____

Adjuster name ____ Phone ____________________

Other Vehicle Information:

Driver name and address ____

Insured name and address ____
(IF DIFFERENT THAN DRIVER)

Insurance Co. ____ Policy # ____________________

Insurance address ____ Claim # ____________________

Adjuster name ____ Phone ____________________

Attorney Information:

Attorney name ____ Phone ____________________

Address ____

Accident Information:

Date of Accident____________________ Time__________ Road Conditions ____________________

Accident Location: City/State______________________ Street/Intersection______________________

No. of people in your vehicle_____ In other vehicle_____ Police notified? ☐ Yes ☐ No Accident report filed? ☐ Yes ☐ No

Your seating at impact: ☐ Driver ☐ Passenger in the: ☐ Front Seat ☐ Back Seat on the: ☐ Left ☐ Right ☐ Center

Body position at impact: ☐ Straight ahead ☐ Facing Left ☐ Facing Right ☐ Bent over ☐ Other__________________

Head position at impact: ☐ Straight ahead ☐ Turned Left ☐ Turned Right ☐ Other______________________

How were you restrained? ☐ Lap belt only ☐ Lap and chest belt ☐ Activated air bag ☐ None

Seat headrest set to: ☐ Back of head ☐ Back of neck ☐ None

Were you aware of the approaching collision prior to impact? ☐ Yes ☐ No

Was your vehicle: ☐ Stopped, holding brakes ☐ Stopped, no brakes ☐ Slowing ☐ Accelerating ☐ Steady______MPH

Was the other vehicle moving at time of impact? ☐ Yes, at approx. ______MPH ☐ No

Did your body hit any part of your vehicle? ☐ Yes ☐ No If yes, which part of the car did you hit -- and with what part of your body? ______________________________

Did you experience a flash of light or explosion in your head at impact? ☐ Yes ☐ No

Did you lose consciousness (black out)? ☐ Yes ☐ No If yes, for how long? ______________________________

Please describe, to the best of your knowledge, what happened during the accident: ______________________________

____

____

____

Did you receive any medical care at the accident scene? ☐ Yes ☐ No If yes, please describe______________________________

____

Did you go to a hospital because of this accident? ☐ Yes ☐ No If yes, hospital name/city ______________________________

How did you get to the hospital?__________________What X-rays or other images were taken? ______________________________

What treatments were you given?______________________________ How long did you stay?

Have you seen any other doctors since the accident? impact? ☐ Yes ☐ No

If yes, doctor name and address______________________________

What type of treatment did you receive? ______________________________

What pain or problems are you having that you feel are related to this accident?______________________________

____

____

______________________________ Are these problems getting ☐ Worse ☐ Better ☐ About the same

Have you ever felt like this before? ☐ Yes ☐ No If yes, when? ______________________________

Describe any current symptoms and problems you feel are NOT related to this accident: ______________________________

____

____

Have you lost work as a result of this accident? ☐ Yes ☐ No If yes, how much? ______________________________

What activity restrictions do you notice as a result of thyis accident? ______________________________

____

X______________________________ Date__________________

PATIENT SIGNATURE (IF RELATIVE, STATE RELATIONSHIP)