AUTO ACCIDENT INFO REQUIRED

Today's Date (MM/DD/YYYY)

Date of Accident: (MM/DD/YYYY)

State of Accident

If your accident happened in the state of Kansas (a no fault state) then claims are filed through your car insurance even if the other driver was at fault!

Claim Number

Adjuster's Name

Adjuster's Phone Number

Provider will complete the following section

Name of Insurance Company

Mailing Address

Hampton Chiropractic

Dr. Trevor Hampton

1131 E. North Ave | www.beltonchiropractor.com | 816.535.5101

AUTO ACCIDENT QUESTIONNAIRE

Please answer all questions completely.

Patient Name _____ State of Accident _____ Today's Date (MM/DD/YY) _____

Patient was: ◯ Driver ◯ Passenger ◯ Other ☐ front seat ☐ back seat

Vehicle Patient was riding in: Year _____ Make _____ Model _____ ☐ vehicle was stopped Est speed MPH _____

Other Vehicle in accident: Year _____ Make _____ Model _____ ☐ vehicle was stopped Est speed MPH _____

Time of Day at impact: ◯ Dawn ◯ Day ◯ Dusk ◯ Night

Road Condition at impact: ◯ Dry ◯ Wet ◯ Damp

Seat Belt at impact: ◯ None ◯ Not Wearing ◯ Wearing ◯ Not Sure

Shoulder Harness at impact: ◯ None ◯ Not Wearing ◯ Wearing ◯ Not Sure

Head Position at impact: ◯ Straight ◯ Turned Left ◯ Turned Right

Hand Position at impact: ◯ One on wheel ◯ Not Sure ◯ Two on wheel

Were you struck from:
◯ Front ☐ center ☐ right ☐ left
◯ Rear ☐ center ☐ right ☐ left
◯ Side Impact ☐ right rear ☐ right front ☐ left rear ☐ left front

Did you feel your body go: ◯ Forward then back ◯ Back then forward

Head Rest at impact: ◯ None ◯ Integral ◯ Adjusted in _____ Position

Were the brakes on?	◯ Yes	◯ No	Was there a second collision outside the vehicle?	◯ Yes ◯ No
Transmission	◯ Manual	◯ Auto		
Were you aware of the imposing collision?	◯ Yes	◯ No	Was there a second collision inside the vehicle?	◯ Yes ◯ No
Were you wearing glasses?	◯ Yes	◯ No	Were there tickets issued to you?	◯ Yes ◯ No
Were they still on after the collision?	◯ Yes	◯ No	To the driver of your vehicle (if not you)?	◯ Yes ◯ No
Did you lose consciousness? (if Y, list # seconds)	◯ Yes _____	◯ No	To the drive of the other vehicle?	◯ Yes ◯ No
Were the police on the scene?	◯ Yes	◯ No	Was fault determined?	◯ Yes ◯ No
Was there a report made?	◯ Yes	◯ No		

Dr. Trevor Hampton
1131 E. North Ave ■ www.beltonchiropractor.com ■ 816.535.5101

The vehicle was: ◯ Totalled ◯ Drivable ◯ Not Drivable Est. Property Damage: _____

Were other people in your car injured? ◯ Yes ◯ No # of other people in car: _____

After the accident, were you: ◯ Dizzy ◯ Disoriented ◯ In Shock ◯ Bleeding (where?) _____

The first symptom appeared _____ hours after the accident.

Were you treated at the scene? ◯ Yes ◯ No ◯ Taken by _____ to _____ hospital

◯ Went Home ◯ Went to Dr. _____ office ◯ Other

◯ Went to _____ hospital later _____ (date/time)

At hospital: ☐ X-Ray ☐ Lab ☐ Collar ☐ Medication _____

☐ Other _____

Have you lost any days from work? ◯ Yes _____ (# of days) ◯ No

Describe accident in detail: _____

_____

_____

_____

_____

_____

Insurance Companies Involved:

My company: _____

Company responsible for bill: _____

Have you been contacted by an Insurance Adjuster or Representative regarding this claim? ◯ Yes ◯ No

Do you have an attorney that has advised you in this case? ◯ Yes ◯ No

_____ _____

Attorney's Name Address

_____ _____ _____ _____

City State Zip Phone Number

_____ _____

Patient Signature Date (MM/DD/YYYY)