

COLLISION INFORMATION

Daniel Kiefat DC • 2525 DeMers Ave Ste B • Grand Forks, ND 58201

Date: _____

Chart #: _____

Name: _____

Where did collision occur? Street: _____ City _____ State _____

Collision Date: _____ Collision Time: _____ AM PM

Was the road: Dry Wet Snowy Icy

Were you the: Driver Front Middle Passenger Front Right Passenger Back Left Back Middle Back Right

Describe what happened:

CRASH DETAILS

Yes No If driving, were both hands on the wheel at impact?
 I was not the driver.

Yes No If passenger, did your hands brace yourself?
 I was the driver.

Yes No Did you have your seat belt and shoulder strap on?

Yes No Was your seat up at the time of impact?

Yes No Were you wearing a bulky coat or slipper pants?

Yes No Did the seat belt engage?

Yes No Did the airbag engage?

Yes No Did you hit the dash, steering wheel or window?

Yes No Did you know you were going to be hit?

Yes No Did you brace yourself with hands or feet?

Yes No If driving, was your foot on the brake at impact?
 I was not the driver.

Yes No Was your head turned at impact?

Yes No Were you leaning forward at impact?

Yes No Did your glasses fly off at impact?

Yes No Was your body turned at the moment of impact?

Yes No Did you get hit into another car, tree, railing etc.?

Yes No Was there any damage or marks on your vehicle, the vehicle that hit you, or another object that was hit?
What part(s) was hit on the vehicle you were driving? _____

1. What was the make and model of - The vehicle were you in? _____
The other vehicle? _____

2. What kind of seat were you in? Bucket Bench Fabric Leather/Vinyl

3. Did the car have headrests? Yes No

4. Did you hit your head on the headrest? Yes No On the back window if in a small truck? Yes No

5. Where was the headrest position in regards to the center of your head: Below Level With Above

6. Was anyone else in the car you were in at the time of the accident? Yes No If YES please list who and your relationship:
(Name) _____ - (Relationship) _____ (Name) _____ - (Relationship) _____
(Name) _____ - (Relationship) _____ (Name) _____ - (Relationship) _____

7. Is there anything else you want us to know? _____

INJURY

1. Did your head hurt after the collision? Yes No
2. Did your TMJ/jaw hurt after the collision? Yes No
3. How soon after the collision did you notice any pain? _____
4. Have you lost any days of work due to your accident? Yes No Dates: _____

Check symptoms or problems that you have noticed since your accident:

- | | | | | | |
|---|---|--|---|---|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Balance |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Painful Breathing | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Head Feels Heavy | <input type="checkbox"/> Ability to Read | <input type="checkbox"/> Ability to Listen |
| <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Nausea | <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Pins/Needles in Arms | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Loss of Taste |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Loss of Appetite | <input type="checkbox"/> Irritability | <input type="checkbox"/> Pins/Needles in Legs | <input type="checkbox"/> Ears Buzz | <input type="checkbox"/> Loss of Smell |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Increase of Appetite | <input type="checkbox"/> Stomach Upset | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Feet Cold |
| <input type="checkbox"/> Neck Stiffness | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Constipation | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Concentration | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Depression | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Symptoms Other than Above: _____ | | | | |

PROVIDERS SEEN

List all providers seen since the injury occurred:

1. Clinic/Doctor/Hospital Name: _____ City: _____
2. Clinic/Doctor/Hospital Name: _____ City: _____
3. Clinic/Doctor/Hospital Name: _____ City: _____
4. Clinic/Doctor/Hospital Name: _____ City: _____
5. Clinic/Doctor/Hospital Name: _____ City: _____

- Yes No Do you have pictures of your vehicle? Where is it being repaired? _____
- Yes No Do you have a copy of the police report? _____

INSURANCE INFORMATION

Have you received PIP (Personal Injury Protection) forms from your insurance company?

- Yes No - IF NO, call your insurance immediately to request forms to open a PIP claim for your injury.

Have you submitted your completed PIP (Personal Injury Protection) forms to your insurance company?

- Yes Date Submitted: _____

- No IF NO - Complete and submit to your insurance immediately as you are responsible for payment on your account until your insurance receives these forms and opens a PIP claim for your injury.

Your Car Insurance: _____ Claim #: _____

Adjuster Name: _____
Phone #: (_____) _____ - _____ Ext _____
Email: _____

Claims Fax #: (_____) _____ - _____
Address: _____

Other Driver's Car Insurance: _____ Claim #: _____

Attorney Yes No Are You Working with an Attorney?

Name: _____ Phone #: (_____) _____ - _____

Patient Signature: _____

Date: _____