CHIROPRACTIC LIFE CENTER

Mark R. Johansen, DC · James L. Andrews DC

12762 S.E. Stark Street · Plaza 125 Bldg. D · Portland, Oregon 97233 · Phone: 503.255.7746 · Fax: 503.255.0818 · clcpdx.com

Auto Accident Report

Today's Date_____

Name_____Phone_____

Address_____City/State/Zip_____

Date of accident_____Time_____

Where did the accident occur?_____

Please describe the accident._____

Did the police come? Were there citations?_____

Was your body turned or were you trying to restrain anyone?_____

Where did you hurt after the accident?_____

Where were you taken?_____Treating Doctor?_____

What was done there?_____

Medications taken?_____

Are you receiving any treatment currently?_____

What are your present complaints?_____

How much work have you missed?_____

Name of your insurance company_____phone #_____

Name of person insured under this policy_____

Claim #_____Claim Rep's name_____

Responsible party's name:_____Their insurance:_____

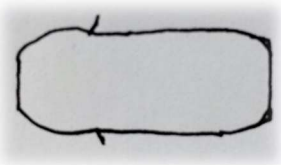
Your Attorney's name & information:_____

Have you been in any previous accidents and when ?_____

Accident Details (please place a ✓ below yes or no)

Y N	Y N	Y N
Wearing Seatbelt?	Bruising?	Work Vehicle?
Seatbelt Held w/impact?	Head Impact?	Anticipate accident?
Foot on brake?	Did you "see stars"?	Braced for impact?
Headrest present?	Loss of Consciousness?	Hearing changes?
Airbags deployed?	Dizziness?	Vision changes?

Please indicate with an ✖ where you were in the car, and with an arrow ↘ the direction of impact



Vehicle damage estimate: $_____