ORTHOKANSAS, LLC

Motor Vehicle Accident

Patient Name:_____ DOB:_____

Date of Accident:_____ Time:_____ Location:_____

Name of Auto Insurance:_____ Claim#:_____

Address to Send Claims:_____

Adjuster Name:_____ Phone#:_____

Mechanism of Injury

Seatbelt?	☐ YES	☐ NO	Were You the Driver?	☐ YES	☐ NO
Head-on Collision?	☐ YES	☐ NO	Were You the Passenger?	☐ YES	☐ NO
Hit Broadside?	☐ YES	☐ NO	Did You Strike the Windshield?	☐ YES	☐ NO
Struck From Behind?	☐ YES	☐ NO	Did You Strike the Headrest?	☐ YES	☐ NO
Did You Strike the Dash?	☐ YES	☐ NO	Did You Lose Consciousness?	☐ YES	☐ NO

Did you experience immediate pain? ☐ YES ☐ NO If no, when did pain occur?

_____

Please check affected areas: ☐ Head ☐ Neck ☐ Upper Back ☐ Lower Back

Arm ☐ LT ☐ RT Leg ☐ LT ☐ RT

Were you seen at a hospital after the accident? ☐ YES ☐ NO

If yes, please give name and address:_____

Were X-rays taken? ☐ YES ☐ NO What views were taken?_____

Please list all treatments (including dates) with Medical Doctor, Chiropractor, Physical Therapy and all diagnostic testing:

1._____

2._____

3._____

4._____

5._____

Please Complete Side 2 In Full →

Have you missed work? ☐ YES ☐ NO

Are you presently off work? ☐ YES ☐ NO

If yes to either, who authorized time off and list date(s):

_____

_____

_____

_____

Do you have any history of problems involving affected area(s)? ☐ YES ☐ NO

If YES, please explain:_____

_____

_____

_____

_____

Have you had any problems with insurance company paying medical bills or lost wages? ☐ YES ☐ NO

If YES, please explain:_____

_____

_____

_____

_____

Do you have an attorney or is there litigation pending? ☐ YES ☐ NO

If YES, please list attorney's name, address and explanation of status:_____

_____

_____

_____

_____

Please list any other pertinent information or comments which may assist in your treatment:

Signature:_____ **Date:**_____