Center for Life Chiropractic, P.C.

1004 NW Milwaukee Ave. Suite 200

Bend, OR 97701

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Accident History

Name: ____ Date: _____/_____/__________

DOB: _____/_____/__________ Social Security #: __________-____________-____________

Address: ____

City: ____________________ State: _____________ Zip Code: ________________________

Home Phone #: __________________________ Cell Phone #: __________________________

Date of accident: ______/______/________ Time of accident: ________________ AM / PM

Location of accident: ____

Name of Insurance: _______________________Claim #: ______________________________

Adjuster name & Phone No: ____

Other vehicle's insurance info: ____

Please describe the incident: ____

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How much damage occurred? ___________________ How fast were you driving? __________

Number of people in vehicle: ____________________ Were you wearing seat belts? ________

If hit from behind, how fast was the other vehicle going? ______________________________

Did you go to the ER or receive any other medical care because of the accident? YES NO

If yes, please explain: ____

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What are your complaints and symptoms related to the accident?

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Signature: ____