1530 N 115th St. #302
Seattle, WA 98133
T: 206-355-6781
F: 206-365-0663

13433 NE 20th ST. #D
Bellevue, WA 98005
T: 425-451-4301
F: 425-957-1406

15228 Woods Creek RD. SE
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# ACCIDENT REPORT

**Date: _____/_____/_____** **SSN: _____ - _____ - _____**

Name:_____ Phone: (_____)_____

Address_____City:_____State:_____Zip_____

Employer _____ Work Phone (_____) _____

## Insurance

Do you have Personal Injury Protection (PIP) coverage? **Yes** **No**

Do you have Uninsured Motorist Protection (U/M)? **Yes** **No**

What are the policy limits for PIP? $_____ What are the policy limits for U/M? $_____

Your Auto Insurance Co.: _____ Phone: (_____)_____

Address: (where to submit claim)_____

_____

## At Fault Party (found on Police report)

Name:_____Phone: (_____) _____

Address:_____City:_____State/Zip_____

Insurance Co.:_____ Policy Number: _____

Have you obtained an attorney for this case? **Yes** **No**

Attorney or Law Firm Name: _____

Address: _____ City: _____ State:____ Zip: _____

Office Phone Number: (_____)_____ Fax Number: (_____)_____

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## History of Present Injury

**Date of Accident:_____/_____/_____ Approximate Time of Accident _____AM/PM**

Driver ☐ Passenger ☐ Pedestrian ☐ Was safety belt worn? **Yes No**

Direction patient's car was going: **N S E W** Street/Road Name:_____

Bisecting road: _____ City or Town: _____State/Zip_____

Was your car: **Stopped/Moving/Turning R/L** Where was your car struck?_____

Make of your vehicle:_____ Other vehicle:_____

# of cars involved:_____ # of people:_____ Was a Police report** made? **Yes No**

****(It is very important we get a copy for your file)****

Did you see the accident coming? **Yes No**

Upon impact, which way was your body thrown? **Forward, Backward, Left, Right**

State which area of your body were immediately affected by the accident?_____

_____

Were you able to get out of vehicle and walk? **Yes No** Could you move all parts of body? **Yes No**

***Additional Information:***_____

_____

_____

Was an Ambulance called? **Yes No** Did you go to hospital? **Yes No** If yes, what was done? **X-Ray, Examination, Medication** If medication was given, what was nature?_____

Referral to other Doctor?_____ Length of hospital stay?_____

Were are you able to sleep comfortably the night of the accident? **Yes No**

What discomfort did you experience, if any?_____

_____

_____

What discomfort did you experience the ***next day***?_____

***Two days*** after?_____ A ***week*** later?_____

What areas ***currently*** are your chief complains? **(1)**_____ **(2)**_____

**(3)**_____ **(4)**_____ **(5)**_____

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Since accident, any new or noticed increase in headaches? **Yes** **No** Dizziness? **Yes** **No**

Grinding sensations within the neck? **Yes** **No** Weakness? **Yes** **No**

Decreased range of motion? _____ Difficulty swallowing? **Yes** **No**

Pain or numbness radiating into the right or left arms or hands? _____

Does the pain increase with movement? **Yes** **No** Primarily to where? _____

Does the pain increase with respiration? **Yes** **No** Any change in digestion? **Yes** **No**

Are you experiencing any pains radiating into legs? **Right** **Left**

Does the pain increase to the low back if you cough? **Yes** **No**

Have you noticed any change in your sleeping patterns?_____

**From the time of the accident, have there been any of the following:**

| | | | | | |
|---|---|---|---|---|---|
| Eye Complains | ☐ | Ear Complains | ☐ | Lapses of Consciousness | ☐ |
| Difficulty in Swallowing | ☐ | Chest Pains | ☐ | Numbness of Extremities | ☐ |
| Behavioral Changes | ☐ | Insomnia | ☐ | Burning Muscle Pain | ☐ |
| Mood Changes | ☐ | Restlessness | ☐ | | |
| Clumsiness | ☐ | Headaches | ☐ | | |

Loss of strength or difficulty moving the arms or legs? ☐

Tingling of the arms or legs ☐ **Right or Left**?_____

Please explain any of above: _____

_____

_____

Have you been examined by anyone else for this accident? **Yes** **No** By Whom? _____

_____

**********

***Thank you for completing this form as accurately as possible. This information is considered CONFIDENTIAL and will only be released upon written authorization from you.***

**********

Please acknowledge ***(by signing below)*** that you have completed this form as accurately and as completely as possible.

_____ _____

Patient Signature ***(If minor, signature of Parent or Guardian)*** Date