

# POWER Chiropractic Clinic

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## MVA/WC Initial Visit Form

1. Date of accident: \_\_\_\_\_ Number of cars involved in accident: \_\_\_\_\_
2. Auto you were in: Year: \_\_\_\_\_ Make: \_\_\_\_\_  
Model: \_\_\_\_\_  
Damage: \_\_\_ Minor \_\_\_ Major \_\_\_ Totaled \_\_\_ approx.  
\$ \_\_\_\_\_  
Where you the owner of the car: YES / NO
3. Other auto(s): Year: \_\_\_\_\_ Make: \_\_\_\_\_ Model: \_\_\_\_\_  
Damage: \_\_\_ Minor \_\_\_ Major \_\_\_ Totaled \_\_\_ approx.  
\$ \_\_\_\_\_  
Area damaged: \_\_\_ Front \_\_\_ Rear \_\_\_ Driver side \_\_\_ Passenger side
4. Street/Intersection  
Name(s): \_\_\_\_\_  
City/State: \_\_\_\_\_
5. Was it \_\_\_ Intersection \_\_\_ Light/Stop sign \_\_\_ Not intersection  
If at a light, was it \_\_\_ Green \_\_\_ Yellow \_\_\_ Red \_\_\_ Turn arrow  
Street surface: \_\_\_ Dry \_\_\_ Wet \_\_\_ Icy \_\_\_ Gravel \_\_\_ Other: \_\_\_\_\_  
Visibility: Good \_\_\_ Glare \_\_\_ Sun \_\_\_ Day \_\_\_ Night \_\_\_
6. How fast and in what direction was the **other** car moving when you hit?  
\_\_\_\_\_
7. How fast and in what direction was **your** car moving when it hit?  
\_\_\_\_\_
8. Where were you sitting in the vehicle?  
\_\_\_ Driver \_\_\_ Front passenger \_\_\_ Passenger in the back left/right/center  
(please circle)  
\_\_\_ Riding in truck bed \_\_\_ Motorcycle driver/passenger (Please circle)  
\_\_\_ Other- -Please specify: \_\_\_\_\_
9. How was your body positioned at the time of the accident?  
\_\_\_ Looking downward doing something else \_\_\_ Looking at the accident coming  
\_\_\_ Looking at passenger \_\_\_ Looking straight ahead  
\_\_\_ Turned to the left/right (please circle) \_\_\_ Looking at oncoming traffic  
\_\_\_ Looking in the rear view mirror \_\_\_ Looking at the driver  
\_\_\_ Other- - Please specify: \_\_\_\_\_

10. What area(s) on your car were hit?

Front passenger corner     Front driver side corner     Front bumper  
 Passenger side     Driver side     Rear passenger corner  
 Rear driver side corner     Rear bumper     Rear trailer  
 Totaled     Head on collision  
 Other: \_\_\_\_\_

11. My body hit the  Steering wheel     Side panel     Head rest  
 Seat with my chest/abdomen/head/face     Upper back (please circle)  
 Door     Dashboard     back of driver's seat     Pavement  
 Console     Other- Please explain:  
\_\_\_\_\_

12. The following parts of my body hit:  Face     Chest     Arm     Shoulder  
 Hip     Abdomen     Wrist     Hand     Fingers     Nose  
 Forehead     Neck     Shin     Thigh     Knee     Other- -Please explain:  
\_\_\_\_\_

13. Additional accident description: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

14. How and when did the pain begin?  
\_\_\_\_\_

15. Was there warning before impact? Yes/No

16. Where you able to brace for impact? Yes/No

17. Did the airbag deploy? Yes/No

18. Does your car have a headrest? Yes/No How high? Head  Mid Neck   
Unknown

Do you recall hitting your head? \_\_\_\_\_ Do not recall if I hit my head \_\_\_\_\_

As a result of the accident were you:

Shaken but could function  
 Unable to move certain body parts

Please explain what parts and why: \_\_\_\_\_

Bruised or bleeding (please describe injuries) \_\_\_\_\_

Rendered unconscious     Able to get up/out of car and walk unaided

Dazed     Vague about what happened

Name: \_\_\_\_\_ Claim # \_\_\_\_\_

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**Insurance Information:**

Name of insured \_\_\_\_\_ Date of Birth \_\_\_\_\_

Date injury occurred (date of accident) \_\_\_\_\_

Your relationship with insured \_\_\_\_\_

Policy # \_\_\_\_\_ Claim#/ID \_\_\_\_\_

Insurance Company

Name \_\_\_\_\_

Insurance Claims/Billing

Address \_\_\_\_\_

\_\_\_\_\_  
(City, state and zip)

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**C.A. Complete Below:**

19. Police Report? \_\_\_\_\_ Ambulance? \_\_\_\_\_ Fire Dept.? \_\_\_\_\_

20. Witness? \_\_\_\_\_

21. Other Related Injuries?

\_\_\_\_\_  
22. Prior MVA? Year?

\_\_\_\_\_  
23. Current Rx: \_\_\_\_\_

\_\_\_\_\_  
24. Long Term Rx:

\_\_\_\_\_  
25. Prior Major Injuries?

\_\_\_\_\_  
26. Prior Surgeries?

\_\_\_\_\_  
27. Time Loss Work Status: \_\_\_\_\_ Weeks Days 1 2 3 4 5

28. Did you go to Emergency Room/ Urgent Care?

\_\_\_\_\_  
29. Did you get x-rayed? \_\_\_\_\_

\_\_\_\_\_  
30. Did you follow-up or see a Physician?

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Name: \_\_\_\_\_ Claim # \_\_\_\_\_

