INSURANCE INFORMATION
MOTOR VEHICLE ACCIDENTS

Note: The information given is not your name and address or the person who hit you, but the auto insurance companies involved and their addresses and the adjusters and claim numbers assigned to your accident. **YOU CAN TAKE THIS HOME WITH YOU, BUT YOU MUST RETURN IT BY YOUR SECOND VISIT – OR WE WILL BE UNABLE TO SEE YOU UNTIL YOU HAVE ALL THIS INFORMATION TO OUR OFFICE**

YOUR CAR INSURANCE INFORMATION: (Or the person whom you were riding with)
MEDICAL PAY: ***(You may or may not have this, if yes, we need the declaration page of your policy)***

Insurance Company: _____
Address: _____
City/State/Zip: _____
Phone: _____
Claim Number: _____
Adjusters Name: _____

INSURANCE COMPANY OF THE PERSON WHO HIT YOU

Insurance Company: _____
Address: _____
City/State/Zip: _____
Phone: _____
Claim Number: _____
Adjusters Name: _____

YOUR HEALTH INSURANCE:

Insurance Company: _____
Address: _____
City/State/Zip: _____
Phone: _____
Policy Number: _____

ATTORNEY ***(If you have retained an attorney due to this accident – If you get one at a later date, let us know)***

Name: _____
Address: _____
City/State/Zip: _____
Phone: _____

KNOW THE LAW: *IN MISSOURI, YOU ARE ENTITLED TO BILL ALL INSURANCE COMPANIES THAT APPLY. MISSOURI INSURANCE REGULATION 4CRS 190-17.100(3) STATES: "IN NO EVENT SHALL AN INSURER REQUEST AN INCRESE IN PREMIUM IN CONNECTION WITH ANY CLAIM ARISING OUT OF ANY ACCIDENT FOR WHICH THE INSURAED IS NOT AT FAULT".*

VEHICLE ACCIDENT REPORT

WEST END CHIROPRACTIC & REHAB CTR.
305 UNION BLVD.
ST. LOUIS, MO 63108

Name _____

1) Date of Accident ____ / ____ / ____ 2) Time of Accident ____ : ____ (AM / PM)

3) Were you: A) Driver B) Passenger (Front) C) Passenger (Rear) D) Pedestrian

4) Were you wearing seatbelts? (Y/N)

5) Type of Vehicle: A) Auto B) Truck C) Van D) Motorcycle E) Motorhome F) Bicycle

6) How accident occurred: A) Struck by another vehicle B) Struck another vehicle C) Struck a stationary object D) Other

7) Where was your vehicle hit? A) Front B) Rear C) Rt. Side D) Lft. Side E) Rt. Front F) Lft. Front G) Rt. Rear H) Lft. Rear

8) Where was other vehicle hit? A) Front B) Rear C) Rt. Side D) Lft. Side E) Rt. Front F) Lft. Front G) Rt. Rear H) Lft. Rear

9) Your approximate speed ____ MPH 10) Other vehicle approximate speed ____ MPH

11) What occurred at the moment of impact? (Circle as many as apply)

A) Tensed body for impact B) Neck whipped forward & back C) Spine torqued and twisted D) Thrown over seat
E) Thrown from vehicle F) Pinned in vehicle G) Thrown from side to side H) Cut and bruised

12) Did you strike your: (Circle as many as apply)

A) Head	Against the: 1) Dashboard	2) Windshield	3) Steering Wheel	4) Rt. Door	5) Lft. Door	6) Seat Frame	7) Unknown Object
B) Shoulder	(Lft./Rt.) - Against the: 1) Dashboard	2) Windshield	3) Steering Wheel	4) Rt. Door	5) Lft. Door	6) Seat Frame	7) Unknown Object
C) Arm	(Lft./Rt.) - Against the: 1) Dashboard	2) Windshield	3) Steering Wheel	4) Rt. Door	5) Lft. Door	6) Seat Frame	7) Unknown Object
D) Elbow	(Lft./Rt.) - Against the: 1) Dashboard	2) Windshield	3) Steering Wheel	4) Rt. Door	5) Lft. Door	6) Seat Frame	7) Unknown Object
E) Wrist	(Lft./Rt.) - Against the: 1) Dashboard	2) Windshield	3) Steering Wheel	4) Rt. Door	5) Lft. Door	6) Seat Frame	7) Unknown Object
F) Hip	(Lft./Rt.) - Against the: 1) Dashboard	2) Windshield	3) Steering Wheel	4) Rt. Door	5) Lft. Door	6) Seat Frame	7) Unknown Object
G) Knee	(Lft./Rt.) - Against the: 1) Dashboard	2) Windshield	3) Steering Wheel	4) Rt. Door	5) Lft. Door	6) Seat Frame	7) Unknown Object
H) Ankle	(Lft./Rt.) - Against the: 1) Dashboard	2) Windshield	3) Steering Wheel	4) Rt. Door	5) Lft. Door	6) Seat Frame	7) Unknown Object

13) Were you rendered unconscious? (Y/N) 14) Did you receive medical attention at the scene of the accident? (Y/N)

15) Where did you go immediately following the accident? A) Hospital B) Home C) Personal Doctor D) To this office E) Resumed activities

16) Were you: (Circle as many as apply) A) Shaken B) Disoriented

Did you have any physical complaints before the accident? (Y/N) If "YES" please describe: _____

In your own words, please describe accident: _____

How did you feel immediately after the accident? _____

Important: This form may be used in the determination of insurance benefits and/or litigation for compensation. It is imperative that this form be filled out completely to protect your rights of compensation.