HIGH DEFINITION PHYSICAL THERAPY
9785 S. Maroon Circle, STE 157, Englewood, CO 80112
phone: 303-792-0670 fax: 303-790-4576

ACCIDENT INFORMATION (IF APPLICABLE)

Date of Injury: _____

First Party Insurance Company: _____

Adjuster: _____ Phone: _____

Claim #: _____ Fax: _____

At Fault Insurance Company: _____

Adjuster: _____ Phone: _____

Claim #: _____ Fax: _____

Attorney: _____ Law Firm: _____

Phone: _____ Fax: _____

BASIC INFORMATION ABOUT THE ACCIDENT

Date Accident Occurred: _____ Time of Day Accident Occurred: _____

Describe how the accident occurred: _____

_____

Describe the condition or symptoms caused by the accident: _____

_____

AUTO-ACCIDENT SPECIFIC INFORMATION

Were you the: ☐Drive ☐Passenger ☐Pedestrian ☐Bicyclist

Were you moving: ☐Quickly ☐Slowly ☐Stopped

Type of Impact: ☐Rear end ☐Front ☐Side ☐Roll over

Brakes on Impact: ☐Locked Tight ☐Loosely Applied ☐Foot not on brake

Wearing Seat Belt? ☐Yes ☐No

Was the car equipped with Air Bags? ☐Yes ☐No Did they deploy? ☐Yes ☐No

Did you see the impact coming? ☐Yes ☐No Did you brace yourself for impact? ☐Yes ☐No

On impact, your head was looking.. ☐Ahead ☐Behind ☐Up ☐Down ☐To the Right ☐To the left

Did your body hit anything inside the car? ☐Yes ☐No Body Part? _____

What did it hit? _____

Head trauma? ☐Yes ☐No Loss of consciousness? ☐Yes ☐No For how long? _____

Do you remember the accident happening? ☐Yes ☐No

Taken by ambulance? ☐Yes ☐No

Hospital? ☐Yes ☐No Name of hospital: _____ How long? _____

Were images taken? ☐Yes ☐No X-ray areas: ☐Neck ☐Mid-back ☐Low-back ☐Other x-rays

Have you followed up with your Primary Care Physician? ☐Yes ☐No