



**OKANAGAN HEALTH & PERFORMANCE**

Family & Sports Chiropractic, Massage Therapy & Physiotherapy

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**AUTO-ACCIDENT FORM**

Name:.....Date:.....

Mailing Address:.....

**Date and Time of Accident:**.....

Who rendered first treatment? .....

**Claim Number:**.....

**Name of your Adjuster:**.....

**Describe the type of accident:**

- Driver
- Passenger
- Pedestrian
- Rear-end collision
- Broadside
- Head-on

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Were you wearing a seatbelt at the time of the accident? Yes..... No.....

Do you recall what happened to you at the moment of impact? (Did you hit anything, head thrown forward and then back, etc.?)

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What symptoms did you experience right after the accident?

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What symptoms do you have right now? .....

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Did your accident occur while on the job? Yes ..... No .....

Have you filled out form 7? (Application for Medical Benefits)

Yes ..... No .....

Have you had a previous motor vehicle accident? If yes, what area(s) were injured?

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I understand that **I** am responsible for payment should the Insurance Co. **refuse** to accept my accident claim.

**Signature:**.....