Blue Pearl Medical Massage, Llc
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Accident Information

Name_____
Date of Accident_____ Location (City and State)_____
Where was your vehicle struck? (Behind, Left, Right, Front)_____
Name of Person Who Hit you?_____
Names of persons in the car_____
Were you moving when you were struck? Y N Approx. Speed?_____
Were your brakes applied? Y N Wearing a seatbelt? Y N Were you the driver?_Y N
Position of head at impact_____ Position of hands at impact_____
Did the airbag deploy?_____ Were you aware of impending collision?_____
Did you strike anything inside the car?_____ Did you feel more than one impact?_____
Were you unconscious? Y N Were you dazed? Y N
When and where did the pain begin?_____
Have you ever had same or similar symptoms/pain? _____
Did you go to hospital Y N If you did, what was done? _____
Did you go to a doctor Y N If you did, Who?_____
Was a police report filed?_____
Was the accident related to work?_____ Did you report it to a superior? Y N
Name and phone # of superior_____

Insurance Information

Auto Insurance Co._____ Policy Number_____
BillingAddress_____
Phone Number_____ Fax #_____
Adjuster's Name_____ Claim Number_____

Other Party's Insurance Co._____ Policy Number_____
Billing Address_____
Phone Number_____ Fax#_____
Adjuster's Name_____ Claim Number_____

Has an Attorney advised you on this matter? Y N
Attorney's Name_____ Phone Number_____
Address_____
Additional Information
_____
_____

Signature_____ Date_____