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?_Y N

Were you aware of impending collision?_Y N

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_____

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