DR. ROBERT E. ANDERSON, D.C.
ANDERSON CHIROPRACTIC
AUTOMOBILE ACCIDENT HISTORY FORM

PLEASE FILL OUT THIS FORM AS COMLETELY AS POSSIBLE.

Name _____Date _____ICBC Claim Number _____
ICBC Adjuster name, phone and email_____
Date of accident _____ Time of accident _____ AM/PM
Place of accident _____
Street City
Road conditions at the time of the accident
( ) Wet ( ) Dry ( ) Icy ( ) Dirt ( )Other _____

Did the police come to the accident scene? Y N
Were you taken to the hospital? Y N
Name of hospital _____ Hospital address (city) _____
How did you get to the hospital? _____
What parts of your body were x-rayed at the hospital? _____
_____
_____

THE FOLLOWING QUESTIONS PERTAIN TO YOU, AS THE PATIENT, AND THE VEHICLE YOU WERE IN.

1. Were you the: ( ) Driver ( ) Passenger
2. Where were you seated in the vehicle? ( ) Front Seat ( )Back Seat
3. Were you aware of the approaching collision prior to impact? Y N
4. Did you lose consciousness (black out) upon impact? Y N
5. Were you wearing a seat belt? Y N If yes, was it a: ( ) lap belt ( ) shoulder-lap belt
6. Was the top of your car's headrest positioned at the:
   ( ) base of your neck ( ) middle of your head ( ) top of your head
7. List the year, make and model of the vehicle you were in:
   Make _____ Model _____ Year _____
8. Was the car stopped at the time of impact? Y N
   If Yes, was the driver's foot on the brake at the time of impact? Y N
   If No, estimate the speed your vehicle was travelling: _____ mph or _____ kph
9. If your vehicle was moving at the time of impact, was it:
   ( ) Slowing down ( ) Gaining speed ( ) Travelling at a steady rate of speed
10. Were you struck from: ( ) Behind ( ) Front ( ) Left side ( ) Right side
11. Please describe, to the best of your knowledge, what happened during the accident.
    _____
    _____
    _____
12. What bleeding cuts did you get during this accident? _____
    _____

13. Did you have any physical complaints BEFORE THE ACCIDENT? Y N
    If yes, please describe in detail: _____
    _____
14. Please describe how you felt:
    a. During the accident _____
    b. Immediately after the accident _____
    c. Later that day _____
    d. The next day _____
15. On what part of the automobile did the following body parts hit:
    Head hit_____ Chest hit _____
    Right or left shoulder hit _____ Right or left arm hit _____
    Right or left hip hit _____ Right or left leg hit _____
    Right or left knee hit _____ Other _____
16. What is the cost damage to the vehicle you were in? _____
17. Which of the following car parts broke during the accident?
    ( ) Windshield ( ) Rt/lft side window ( ) Steering wheel
    ( ) Front seat ( ) Back seat ( ) Other _____
18. Was your body pointed straight forward at the time of the collision? Y N
    If No, which direction was it turned and by how much? _____
19. Was your head pointed straight forward at the time of the collision? Y N
    If No, which direction was it turned and by how much?
20. Have you ever been involved in an accident before? Y N
    If Yes, please describe, including dates and types of accidents, as well as injuries received.
    _____
    _____
21. Do you notice any activity restrictions as a result of this injury? Y N
    If Yes, please describe in detail: _____
    _____
    _____

THE FOLLOWING QUESTIONS PERTAIN TO THE OTHER VEHICLE INVOLVED.

1. What is the year, make and model of the other vehicle?
   Make _____ Model _____Year _____
2. Was the other vehicle moving at the time of the collision? Y N
   If Yes, what was the approximate speed? _____ mph or _____ kph
3. If the other vehicle was moving at the time of the collision, was it:
   ( ) Slowing down ( ) Gaining speed ( ) Travelling at a steady speed

IF YOU HAVE ANY OTHER COMMENTS OR INFORMATION REGARDING YOUR ACCIDENT, PLEASE NOTE THEM HERE: _____
_____
_____

Patient Signature _____ Date _____

I, hereby, consent to share information with ICBC.