

Northgate Chiropractic

11065 5th Avenue NE Suite E, Seattle, WA 98125 · (206) 367-2224 · northgatechiro.com

Motor Vehicle Accident History

Complete on screen or print clearly · Optional fields may be skipped unless needed for billing

Account # (office use) Today's date Date of accident

PATIENT INFORMATION

Legal last name Legal first name Middle

Preferred name Pronouns (optional) Date of birth

Gender identity (optional — respectful care only; never used to deny services)

Woman Man Non-binary Prefer not to say
Self-describe Title (Mx/Mr/Ms/Dr...)

Sex assigned at birth (optional — skip if not needed)

Female Male Intersex Prefer not to say

Relationship / household (optional)

Married Partnered / domestic partner Single
Widowed Divorced Prefer not to say

Street address City State ZIP

Mobile phone Home phone Email

SSN (optional — only if required for insurance billing) Occupation

Employer Work phone

Emergency contact

Name Relationship Phone

PERSON RESPONSIBLE FOR PAYMENT (IF DIFFERENT)

Name Relationship Phone

Address City State ZIP

INSURANCE AND WASHINGTON PIP

Washington Personal Injury Protection (PIP) may cover reasonable and necessary chiropractic care after a motor vehicle accident when coverage applies (RCW 48.22). Your auto insurer may still require a separate PIP application. Bring claim numbers and a police report if available.

Your auto insurance company Policy #

PIP / med-pay claim # (if any) Adjuster name / phone

Other / at-fault carrier (if known) Claim #

Health insurance (if any) Member / ID #

Attorney name (if represented) Attorney phone

I will provide insurance cards / claim info to staff

Yes, today

Later / will send

ACCIDENT DETAILS

Date of accident Time of day City / area of accident

Road condition

Dry

Wet

Icy / snow

Other

2 Were you: Driver Passenger Pedestrian / cyclist / other

2b If in a vehicle, seat position: Front seat Back seat Other

3 Number of people in your vehicle

4 Were you wearing a seat belt? Yes No N/A

5 Lap belt only? Yes No N/A

5b Lap and shoulder harness? Yes No N/A

6 Direction you were headed:

North

South

East

West

Unknown

6b On (street and city)

7 Direction of the other vehicle:

North

South

East

West

Unknown / N/A

7b On (street and city)

IMPACT AND VEHICLES

8 You were struck from: Behind Front Left side Right side

8b Other combination — describe

9 Head position during the accident: Straight ahead Turned right Turned left

9b Other

10 Did any part of your body strike anything inside the vehicle? Yes No

10b If yes, explain

11 Did items become displaced in the vehicle? Yes No

11b If yes, describe

12 Approximate speeds (mph)

Your vehicle

Other vehicle

13 Make / model

Your vehicle

Other vehicle

14 Were the police notified? Yes No

If yes, please provide this office with a copy of the police / collision report when available.

15 In your own words, describe the accident

HOW YOU FELT AND CARE SO FAR

16 Any physical complaints BEFORE the accident? Yes No

16b If yes, describe in detail

17a How you felt DURING the accident

17b IMMEDIATELY AFTER

17c LATER THAT DAY

17d THE NEXT DAY

18 Were you knocked unconscious? Yes No

18b If yes, for how long?

19 Where were you taken after the accident?

20 Treated by another doctor since this accident? Yes No

20b Doctor name / address

20c Type of treatment received

CURRENT SYMPTOMS & FUNCTION

21 Did this accident occur while performing regular job duties? Yes No

22 How do you feel now? #1 problem or area of greatest pain

23 Rate pain (0 = none, 10 = worst). Check one, or two for a range:

0 1 2 3 4 5 6 7 8 9 10

24 Since this injury, is your pain: Improving Getting worse Staying the same

25. How often do you experience the pain?

1–2 hours per day

About half the day

Most of the day

Never goes away

26. How does the pain affect daily activities?

Does not affect activities

Changed how I do things

Stopped some activities

Unable to perform daily activities

27 What increases your pain?

28 What decreases your pain?

29 Have you experienced this problem before? Yes No

29b When?

30 Previous illness or condition affecting present condition? Yes No

30b If yes, describe

31. Other current complaints — describe each, then check a 0–10 rating:

a.		0	1	2	3	4	5	6	7	8	9	10
b.		0	1	2	3	4	5	6	7	8	9	10
c.		0	1	2	3	4	5	6	7	8	9	10
d.		0	1	2	3	4	5	6	7	8	9	10

32 Lost time from work due to this accident? Yes No

Type of employment

Last day worked

33 Involved in an accident before? Yes No

33a If yes, when?

33b Describe the accident(s)

33c Were you injured in prior accident(s)? Yes No

33d Explain

34 List all medications you currently take (prescribed and OTC)

35 List all surgeries (with approximate dates)

Pain regions (optional) — e.g. neck R, low back L, right shoulder:

HEALTH HISTORY CHECKLIST

Mark P = past condition, C = currently experiencing. Answer only as comfortable. This supports clinical safety — not a diagnosis.

P	C	Condition	P	C	Condition
		Heart attack / heart disease			Stroke / TIA
		Arthritis			Gallbladder trouble
		Diabetes			Glaucoma
		Fainting spells			Kidney stones / disease
		Difficulty with urination			Bloody stools
		Difficulty with bowel movements			Anemia
		Cancer			Asthma
		HIV			Ulcers
		Diverticulosis			Menstrual cramping / pelvic pain
		Dizziness			Loss of memory
		Chest pain			Shortness of breath
		Constipation			Diarrhea
		General fatigue			Sudden weight loss
		Nausea			Muscle cramping
		Soreness in joints			Loss of hearing
		Ears ringing (tinnitus)			Headache
		Migraine			Epilepsy / seizures
		Gout			Tuberculosis
		STI (note details if needed)			Knee / hip replacement
		Broken bones			Sprained ankle — right
		Sprained ankle — left			Osteoporosis / low bone density
		Blood clots / DVT			Pregnant or possible pregnancy

Notes / specify (broken bones, STI, etc.)

GENERAL ACTIVITIES

Check all that apply to your usual routine.

Sleep on waterbed	Read in bed	Fall asleep in recliner / couch
Sleep on stomach	Needlework / crafts	Two or more pillows
Sewing	Lift weights / machines	Video games
Exercise regularly	Jog / run	Computer / desk work
Swim	Gym / cardio equipment	Watch television
Exercise × / week	Jog × / week	Screen / game hrs per day

Anything else you would like the doctor to know?

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I certify that the information on this form is true and complete to the best of my knowledge. I understand that incorrect information can be dangerous to my health and may affect insurance benefits. I authorize Northgate Chiropractic and its providers to release information reasonably necessary for treatment, payment, and health care operations to third-party payers, attorneys I designate, and other health practitioners involved in my care related to this accident. I assign and authorize payment of insurance benefits (including Washington PIP / med-pay and any applicable health or liability coverage) directly to Northgate Chiropractic for services rendered. I understand my insurer may pay less than the full charges and that I remain responsible for balances not paid by insurance, except as limited by law or written agreement. Health information I provide may be consumer health data under Washington's My Health My Data Act (MHMDA) and is handled per the clinic's privacy practices (northgatechiro.com/privacy). This form does not replace any separate PIP application my auto insurer may require.

I have read and agree to the authorization above

Patient / guardian printed name

Signature (type full legal name if completing electronically)

Parent or guardian signature required if the patient is a minor.

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OFFICE USE ONLY

Complete after review with the patient. Keep with the chart.

Date of examProviderAccount / case #

PIP / claim verifiedPolice report received

Doctor's comments / examination notes

Provider initialsDateNext visit