Vehicle Accident Report

Name: _____ Date of the accident: _____ Time of the accident: □ AM □ PM

Patient Role: □Driver □Front passenger □Rear passenger □Motorcycle operator □ Motorcycle passenger □ ATV operator □ATV passenger □ Pedestrian □Other_____

Did your car strike the other vehicle? □ Yes □ No **Did another vehicle strike yours?** □Yes □ No

As a result of the accident, were traffic citations issued to you or the driver? □Yes □ No **To the at fault driver?** □ Yes □ No

What is your current occupation? _____ Did you miss any work due to this accident? □ Yes □ No
If yes, how long and what were the dates? _____

Vehicle Size: □Not reported □Subcompact □Compact □Mid-size □Full-size □Other: _____

Make & Model _____ **Speed: _____**

Other Vehicle Size: □Not reported □Subcompact □Compact □Mid-size □Full-size □Other: _____

Make & Model _____ **Speed**: _____

Collision Location: □Not reported □Head On □Front □Behind □Passenger's Side □Driver's Side □Other: _____

Time of Day: □Daylight □Dawn □Dusk □Night **Road Conditions**: □Dry □Damp □Wet □Snow □Ice □Other: _____

Did you know Accident was going to occur?: □Not reported □Yes □No **Patient Ejected?:** □Not reported □Ejected □Not ejected

Patient Struck: □Not reported □Steering wheel □Air bag □Dashboard □Rear-view mirror □Windshield □ Interior □Other:_____

Patient Conscious: □Not reported □Lost consciousness □Did not lose consciousness **Seat Belt**: □Not reported □Used □Not used

Shoulder Belt: □Not reported □Used □Not used **Air Bags**: □Not reported □Deployed □Did not deploy

Head Rest: □Not reported □Above head □ Below head **Position of head at impact**: □ rotated to right □ rotated to left □ forward

Was your vehicle towed from the scene? □ Yes □ No **What was the damage?**_____

Injury Area: □Head □Neck □Shoulders □Upper/Mid Back □Lower Back □Chest/Ribs □Arms □Elbows □Forearms □Wrists □Hands □Abdomen □Buttocks □Pelvis □Hips □Thighs □Legs □Knees □Ankles □Feet □Other: _____

Did you have immediate pain after the accident? □Yes □ No

Did your pain begin □15 min after accident □ several hours after accident □ that night □ the following day □ other _____

How did you feel immediately following the accident? □ Painful □ Dazed □ Disoriented □ Alert

Were you taken to the ER? □ Yes □ No If yes, via □ ambulance □ self □ other:_____

What hospital were you treated at? _____ Were x-rays taken? □ Yes □ No **If yes, of what?**_____

Were you prescribed medication? □ Yes □ No **What was prescribed?** □ NSAID □ Muscle Relaxer □ Pain Killer □ Other:_____

Current chief complaint since accident?_____

Insurance and Attorney Information

Patient Auto ins. co: _____ **Adjuster:**_____ **Phone #**:_____**Claim #:**_____

Medpay Coverage? □Yes □ No

At Fault Driver:_____**Auto Ins. Co**:_____ **Adjuster**:_____**Phone #**: _____ **Claim #**:_____

Attorney:_____ **Phone #**:_____ **Address:** _____

I hereby authorize the doctor to examine and treat my condition as he/she deems appropriate through the use of chiropractic health care, and I give authority for these procedures to be performed. It is understood and agreed the imaging is for examination only and the negatives will remain the property of this office, being on file where they may be viewed.

Patient's/Guardian's Signature: _____ Date: _____

Additional Notes: