Auto Accident Form

Please Circle either Yes or No where appropriate.

Patient's Name: _____ Date: _____

Date of Accident: _____ Time of Accident: _____

Where you in your vehicle, if not, whose vehicle were you in? _____

Where were you in the vehicle? _____

What type of vehicle were you in? _____

What was your vehicle doing immediately prior to impact? _____

Please describe your accident in your own words. _____

_____

_____

_____

_____

Feel free to sketch the accident:

Amount of damage to your vehicle? _____ Road Condition at time of Accident: _____

Visibility at time of Accident: _____ List the number of other vehicles involved: _____

Which vehicle hit the other? _____

Was a police report filed? Yes No Did the air bags deploy? Yes No Did you lose consciousness? Yes No

Did you receive emergency care at the scene? Yes No What was the position of your headrest? _____

List the type of seat restraint, you were wearing, if any: (example: lap belts with or without harnesses)_____

Where did you go immediately after the accident? _____

Did you brace for the impact? Yes No Was the driver's foot on the brake at time of impact? Yes No Unknown

Was the driver's foot knocked off the brake at the time of impact? Yes No Unknown

What was the position of your head and neck prior to impact? _____

What was the position of your arms and hands prior and during impact? _____

What was the type of the other vehicle involved? _____

What was their speed? _____ Where they accelerating? Yes No Unknown

What was the other vehicle's point of impact? _____

What was the amount of damage to the other vehicle? _____

What was the other vehicle doing immediately prior to impact? _____

Patient's Signature: _____ Date: _____

Conyers Family Chiropractic Center 2365 Wall St., Suite 100, Conyers, GA 30013 Phone: (770) 922-8187