FIRST CHOICE CHIROPRACTIC
INJURY & WELLNESS CENTER

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VEHICLE ACCIDENT INFORMATION

Patient Information

Date _____

Patient Name _____

Date of Accident _____ Time of Accident _____ ☐AM ☐PM

Were you the: ☐DRIVER ☐FRONT PASSENGER ☐REAR PASSENGER ☐PEDESTRIAN

How many people were in the accident vehicle? _____

Please describe the accident in your own words: _____

_____

_____

_____

_____

Accident Site

Road / Street Name _____

City _____ State _____

Nearest intersection with Road / Street _____

Driving conditions: ☐DRY ☐WET ☐ICY ☐OTHER _____

Which direction were you headed? _____

Speed you were traveling? _____

Your Vehicle

Make & Model of vehicle you were in:

_____

Were you wearing a seatbelt? ☐YES ☐NO
If YES, what type? ☐LAP ☐SHOULDER

Was vehicle equipped with airbags? ☐YES ☐NO
If YES, did they inflate properly? ☐YES ☐NO

Did your seat have a headrest? ☐YES ☐NO
If YES, what position was it in? ☐LOW ☐MID ☐HIGH

Impact

Did your car impact another vehicle? ☐YES ☐NO
Did your car impact a structure? ☐YES ☐NO

If YES, explain: _____

_____

Were you: ☐SURPRISED BY IMPACT ☐BRACED FOR IMPACT

Did any part of your body strike anything in the vehicle? ☐YES ☐NO

If YES, explain: _____

_____

Was impact from: ☐FRONT ☐REAR ☐LEFT ☐RIGHT ☐OTHER _____

At the time of impact were you looking:
☐RIGHT ☐DOWN ☐STRAIGHT AHEAD ☐LEFT ☐UP

Were both hands on the steering wheel? ☐YES ☐NO
If NO, which hand was on the wheel? ☐Right ☐Left

Was your foot on the brake? ☐YES ☐NO
If YES, which foot was on the brake? ☐Right ☐Left

Other Vehicle

Make & Model of OTHER vehicle: _____

Which direction was other vehicle headed? _____

Speed other vehicle was traveling _____

Police

Did the police come to the accident site? ☐YES ☐NO
Were there any witnesses? ☐YES ☐NO
Was a police report filed? ☐YES ☐NO
Was a traffic violation issued? ☐YES ☐NO
If YES, to whom? _____