

# Vehicle Accident Report

Name: \_\_\_\_\_

Enter the date of the accident: \_\_\_\_\_ Enter the time of the accident: \_\_\_\_\_ AM PM

Patient Role:  Driver  Front passenger  Rear passenger  Motorcycle operator  Motorcycle passenger  
 ATV operator  ATV passenger  Other \_\_\_\_\_

Vehicle Size:  Not reported  Subcompact  Compact  Mid-size  Full-size  Other: \_\_\_\_\_

Travel Direction:  Not reported  North  South  East  West  Other: \_\_\_\_\_

Other Vehicle Size:  Not reported  Subcompact  Compact  Mid-size  Full-size  Other: \_\_\_\_\_

Other Travel Direction:  Not reported  North  South  East  West  Other: \_\_\_\_\_

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

Other: \_\_\_\_\_

Time of Day:  Not reported  Daylight  Dawn  Dusk  Night  Other: \_\_\_\_\_

Road Conditions:  Not reported  Dry  Damp  Wet  Snow  Ice  Other: \_\_\_\_\_

Accident Anticipated?:  Not reported  Yes  No

Patient Ejected?:  Not reported  Ejected  Not ejected

Patient Struck:  Not reported  Steering wheel  Air bag  Dashboard  Rear-view mirror  Windshield

Car 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

Head Rest:  Not reported  Above head  Below head  None

Air Bags:  Not reported  Deployed  Did not deploy

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: \_\_\_\_\_

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: \_\_\_\_\_