Accident Relief Chiropractic

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PATIENT'S REPORT OF ACCIDENT

Name _____ Date _____

Location
of Accident _____City_____ State ____

Date of Accident _____ Time _____ Was police report made? **YES / N O**

Were you: ___ Driver ___ Passenger Were you wearing seatbelts? **YES / NO**

Were you struck from: ___ Behind ___ Right side ___ Left side ___Front

Kind of vehicle
you were in _____ Approx. damages $ _____

Other vehicle _____ Approx. damages $ _____

How did the accident occur? _____

_____

_____

Show what happened

How did you feel after the accident? _____ _____

When did the pain begin? _____ Did your body strike anything in the car? **YES / NO**

If so, what? _____ Did you anticipate the accident? **YES / NO**

Did the vehicle impact any other object? **YES / NO** Were you turned in your seat? **YES / NO**

Were you off work because of this injury? **YES / NO** Have you returned? **YES / NO**

First day off work: _____ Date returned to work: _____

Have you been to the hospital for this injury? **YES / NO** Name of hospital _____

Have you seen other doctors for this injury? **YES / NO** Name of Doctor_____