Vehicle Accident Report

Name_____ File #_____

Date of Accident ___/___/___ Time of Accident ____:____ ☐AM ☐PM

Were you: ☐Driver ☐Front passenger ☐Rear passenger ☐Pedestrian

Were you wearing a seatbelt? Yes / No

Type of vehicle: ☐Auto ☐Truck ☐Van ☐Motorcycle ☐Bicycle ☐Other

Were you: ☐Struck by another vehicle ☐Struck another vehicle ☐Struck a stationary object

Where was your vehicle hit? ☐Front ☐Rear ☐Right Side ☐Left Side

Where was the other vehicle hit? ☐Front ☐Rear ☐Right Side ☐Left Side

Your approximate speed _____MPH Other vehicle approximate speed _____MPH

What occurred at the moment of impact? (Check as many as apply)

☐Tensed body ☐Neck whipped back & forth ☐Spine was twisted ☐Thrown over seat

☐Thrown from vehicle ☐Thrown from side to side ☐Pinned in vehicle ☐Cut and bruised

Did you strike your: (Circle as many as apply)

☐Head	Against the:	Dashboard	Windshield	Steering Wheel	Rt. Door	Lt. Door	Seat Frame
☐Shoulder	Against the:	Dashboard	Windshield	Steering Wheel	Rt. Door	Lt. Door	Seat Frame
☐Arm	Against the:	Dashboard	Windshield	Steering Wheel	Rt. Door	Lt. Door	Seat Frame
☐Elbow	Against the:	Dashboard	Windshield	Steering Wheel	Rt. Door	Lt. Door	Seat Frame
☐Wrist	Against the:	Dashboard	Windshield	Steering Wheel	Rt. Door	Lt. Door	Seat Frame
☐Hip	Against the:	Dashboard	Windshield	Steering Wheel	Rt. Door	Lt. Door	Seat Frame
☐Knee	Against the:	Dashboard	Windshield	Steering Wheel	Rt. Door	Lt. Door	Seat Frame
☐Ankle	Against the:	Dashboard	Windshield	Steering Wheel	Rt. Door	Lt. Door	Seat Frame

Were you rendered unconscious? ☐Yes ☐No Did you receive medical attention at the scene? ☐Yes ☐No

Where did you go after? ☐Hospital ☐Home ☐Doctor ☐This Office ☐Resume Activity

Did you have any physical complaints before the accident? ☐Yes ☐No

Describe_____

In Your own words please describe accident:_____

_____

_____

Has Insurance company been contacted? ☐Yes ☐ No Any claim numbers_____

Your auto insurance company_____ Other party auto insurance company_____

Do you have an attorney? ☐Yes☐ No Name_____ Phone_____

Patient's Signature_____ Date_____