FAYETTEVILLE FAMILY CHIROPRACTIC
ACCIDENT REPORT

Name: ______________________________ Date: ______________________

Date of Accident: ______________________ Time of Accident: ______________________

City of Accident: ______________________ Street of Accident: ______________________

Road Conditions **at time of** accident: WET DRY ICY SANDY Other: ______________
Did police come to the accident scene? YES or NO Did EMS come to the scene? YES or NO
Were you taken to the hospital? YES or NO If yes, which hospital? ______________
How did you get to the hospital? ______________
Were X-rays taken? YES or NO. If yes, which ones? ______________
Were any other procedures done? YES or NO. If yes, what procedures? ______________

THE FOLLOWING QUESTIONS PERTAIN TO YOU AND THE VEHICLE YOU WERE IN

1. Were you the driver or the passenger? ______________
   If a passenger, where were you seated? RIGHT FRONT/ LEFT BACKSEAT / RIGHT BACKSEAT/OTHER
2. Who else was in the vehicle with you? ______________
3. Were you **aware** of the approaching collision prior to impact or did impact catch you by **surprise**? __________
4. Did you receive a head injury? YES or NO
5. Did you lose consciousness (black out) upon impact? YES or NO. If yes, for how long? __________
6. Were you wearing a seatbelt? YES or NO. Shoulder/lap seatbelt? YES or NO.
7. Did the airbag deploy? __________ If yes, which one: DRIVER PASSENGER or BOTH STEERING WHEEL
8. What type of vehicle were you in? SMALL CAR SEDAN SMALL TRUCK LARGE TRUCK SUV
   Year of Vehicle: __________ Make of Vehicle: ______________
9. Was your body pointed straight ahead **at the time of** the collision? YES or NO
   If NO, what direction were you turned? LEFT or RIGHT
10. Was your head pointed straight ahead? YES or NO
    If NO, what direction was your head turned? LEFT or RIGHT
11. On what part of your body struck any of the vehicle's interior?
    a. What part of the head hit: ______________
    b. Right or left Chest hit: ______________
    c. Right or left shoulder hit: ______________
    d. Right or Left arm hit: ______________
    e. Right or Left Hip hit: ______________
    f. Right or Left Leg hit: ______________
    g. Right or Left Knee hit: ______________
    h. Right or Left Ankle hit: ______________
12. What type of discomfort did you feel **at the time** of the accident? (Circle all that apply)

Aching	Annoying	Burning	Deep	Diffuse	Dull
Heavy	Intolerable	Pulling	Sharp	Shock Like	Stabbing
Stiffness	Throbbing	Tightness	Tingling	Other	

13. Where on the body are these symptoms felt? (Circle all that apply)

Head:	Front	Back	Right side of head	Left side of head
Neck:	Front	Back	Right side of neck	Left side of neck
Mid Back:	Right side	Left side	Central	
Low Back:	Right side	Left side	Central	
Abdomen	or	**Chest**		

Ribs:	Front	Back	Right side	Left side
Shoulders:	Front	Back	Right side	Left side
Upper Arm:	Front	Back	Right side	Left side
Elbow:	Front	Back	Right side	Left side
Wrist:	Front	Back	Right side	Left Side
Hand:	Front	Back	Right side	Left side
Hip:	Front	Back	Right side	Left side
Thigh:	Front	Back	Right side	Left side
Knee:	Front	Back	Right side	Left side
Leg:	Front	Back	Right side	Left side
Ankle:	Front	Back	Right side	Left side
Foot:	Front	Back	Right side	Left side

Other: ______________________________

14. Additional symptoms felt **at the time** of the accident? (Circle all that apply)

NONE	Anxiety	Breathing Difficulty	Chest Pain
Depression	Disbelief	Dizziness	Exhaustion
Facial Pain	Genital Pain	Gluteal Pain	Headaches
Irritability	Loss of Appetite	Low Energy	Muscle Spasm
Numbness	Tingling	Rib Pain	Shock
Sleeping Difficulty		Soreness	Stomach pain
Stress	Stunned	Tightness	Tiredness
Upset	Other: ____________________		

15. What is your release status from work? NO WORK / LIGHT WORK / NORMAL WORK
16. Was your vehicle struck in the: REAR FRONT DRIVERS SIDE PASSENGER SIDE OTHER
17. Was the Vehicle stopped **at the time** of the accident? YES or NO
    If YES, was the driver's foot on the brake? YES or NO
    If NO, estimate how fast you were going? __________ MPH. What direction? ________________
18. What did the adjustor estimate vehicle damage to be? ________________
    If unknown amount: **HEAVY MODERATE SLIGHT VISIBLE DAMAGE TOTALED**
19. Was the vehicle towed away from the accident scene? YES or NO
20. **PLEASE DESCRIBE, TO THE BEST OF YOUR KNOWLEDGE, WHAT HAPPENED DURING THIS ACCIDENT:**
    (CONTINUE ON BACK OF PAGE IF YOU NEED MORE SPACE)

____

____

____

____

____

____

THE FOLLOWING QUESTIONS PERTAIN TO THE OTHER VEHICLE INVOLVED IN THE ACCIDENT:

21. Year of vehicle ____________ Make ________________ Model ____________________
22. Was other vehicle moving at time of collision? YES or NO If YES, what was the approximate speed? ________
    What direction were they traveling? ____________
23. What was the other vehicle's damage? **HEAVY MODERATE SLIGHT** visible damage or **TOTALED**