BREAUX BRIDGE CHIROPRACTIC
VEHICLE ACCIDENT REPORT

NAME: ____PT #________DATE: _____/_____/______

1. Date of Accident: ______/______/________ **2. Time of Accident:** _____:____ (AM / PM)

3. Were you? A) Driver B) Passenger (front) C) Passenger (rear) D) Pedestrian

4. Were you wearing seatbelts? ( ) YES ( ) NO

5. Type of Vehicle: A) Auto B) Truck C) Van D) Motorcycle E) Motorhome F) Bicycle

6. How accident occurred:
A) Struck by another vehicle
B) Struck another vehicle
C) Struck a stationary object
D) Other

7. Where was your vehicle hit?
A) Front B) Rear C) Right Side D) Left Side
E) Right Front F) Left Front G) Right Rear H) Left Rear

8. Where was other vehicle hit?
A) Front B) Rear C) Right Side D) Left Side
E) Right Front F) Left Front G. Right Rear H) Left Rear

9. Your approximate speed: _________MPH **10. Other vehicle's speed**: __________MPH

11. What occurred at the moment of impact? (Circle as many as apply)

A) Tensed body for impact
B) Neck whipped backward and forward
C) Spine torqued & twisted
D) Thrown over seat
E) Thrown from vehicle
F) Pinned in vehicle
G) Thrown from side to side
H) Cut and bruised

12. Did you strike your? (Circle as many as apply)

A) Head Against the: 1) Dashboard 2) Windshield 3) Steering Wheel 4) Right Door 5) Left Door 6) Seat Frame 7) Unknown Object

B) Shoulder (L/R) Against the 1) Dashboard 2) Windshield 3) Steering Wheel 4) Right Door 5) Left Door 6) Seat Frame 7) Unknown Object

C) Arm (L/R) Against the 1) Dashboard 2) Windshield 3) Steering Wheel 4) Right Door 5) Left Door 6) Seat Frame 7) Unknown Object

D) Elbow (L/R) Against the 1) Dashboard 2) Windshield 3) Steering Wheel 4) Right Door 5) Left Door 6) Seat Frame 7) Unknown Object

F) Wrist (L/R) Against the 1) Dashboard 2) Windshield 3) Steering Wheel 4) Right Door 5) Left Door 6) Seat Frame 7) Unknown Object

G) Hip (L/R) Against the 1) Dashboard 2) Windshield 3) Steering Wheel 4) Right Door 5) Left Door 6) Seat Frame 7) Unknown Object

H) Knee (L/R) Against the 1) Dashboard 2) Windshield 3) Steering Wheel 4) Right Door 5) Left Door 6) Seat Frame 7) Unknown Object

I) Ankle (L/R) Against the 1) Dashboard 2) Windshield 3) Steering Wheel 4) Right Door 5) Left Door 6) Seat Frame 7) Unknown Object

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13. Were you rendered unconscious? ( ) YES ( ) NO

14. Did you receive medical attention at the scene of the accident? ( ) YES ( ) NO

15. Where did you go immediately following the accident?

A) Hospital B) Home C) Personal Doctor D) This Office E) Resumed Activity

16. Were you? (Circle as many as apply) A) Shaken B) Disoriented

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Did you have any physical complaints before the accident? ( ) YES ( ) NO

If YES, please describe:

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In your own words, please describe the accident:

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How did you feel immediately after the accident?

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