Ord Sports Chiropractic & Wellness
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Auto Accident Form

ACCIDENT INFORMATION

Date and time of Accident: _____ First Name: _____ Last Name: _____

Name of the location/Street on which you were traveling: _____

Where you the: ☐Driver ☐Front Passenger ☐Rear Passenger

Make and model of the vehicle you were occupying: _____

Was this vehicle equipped with airbags? ☐Yes ☐No Did the Airbags inflate? ☐Yes ☐No Were you wearing a seatbelt? ☐Yes ☐No

Did the impact to your vehicle come from the : ☐Front ☐Rear ☐Right Side ☐Left Side ☐Other

In relation to the base of your skull, where was the headset? ☐Above ☐Below ☐At the base

In which direction were you headed? ☐North ☐South ☐East ☐West

Direction the other vehicle was headed? ☐North ☐South ☐East ☐West

During impact, were you facing: ☐Forward ☐Right ☐Left

Did any part of your body strike anything in the vehicle? ☐Yes ☐No Explain: _____

Did the accident render you unconscious? ☐Yes ☐No If yes, for how long? _____

What was the approximate speed of your vehicle? _____ The OTHER vehicle? _____

Were you ☐Aware ☐Surprised by the impact.

What did your vehicle impact? ☐A Vehicle ☐Other If other, please explain: _____

Number of people in the accident vehicle: _____ Please list the names of the victims in this accident: _____

_____

In your own words, please describe the accident: _____

_____

_____

_____

Please describe how you felt immediately after the accident:_____

LEGAL INFORMATION

Did the police come to the accident scene? ☐Yes ☐No Was a police report filed? ☐Yes ☐No

Were there any witnesses? ☐Yes ☐No Was a traffic violation issued? ☐Yes ☐No To whom: _____

Have you retained an attorney? ☐Yes ☐No If yes, whom? _____ Phone: _____

MEDICAL INFORMATION

Have you gone to a hospital or seen any other doctor? ☐Yes ☐No When did you go? ☐Immediately ☐Next Day ☐Two Days Plus

How did you get there? ☐Ambulance ☐Private Transportation Was medication prescribed? ☐Yes ☐No

Name of the hospital and/or attending doctor: _____

Was he/she a: ☐D.D.S ☐M.D. ☐D.C. ☐D.O. Were any X-rays taken? ☐Yes ☐No

Have you been able to work since this injury? ☐Yes ☐No Are your work activities restricted as a result of this injury? ☐Yes ☐No