FLEXFIT CHIROPRACTIC

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Auto Accident Report

Your auto insurance company: _____ **Claim #**: _____
Do you have an attorney representing you? ☐ Yes ☐ No **Name**: _____

Date of accident: _____ **Time of day**: _____ am / pm **City, State**: _____
Was the accident on the job? ☐ Yes ☐ No **Were you in a company vehicle?** ☐ Yes ☐ No
Make and model of *vehicle you occupied*? _____
Make and model of *the other vehicle*? _____
Where were you seated in the vehicle? ☐ Driver ☐ Passenger ☐ Rear seat Other: _____

Were you wearing a seatbelt? ☐ Yes ☐ No **Number of people in accident vehicle**: _____

Direction *you* were headed? ☐ North ☐ South ☐ East ☐ West **On which street?** _____
Direction of *other vehicle*? ☐ North ☐ South ☐ East ☐ West **On which street?** _____
Approximate speed of *your vehicle*? _____ mph ***Other vehicle*?** _____ mph ☐ N/A
Were you struck from: ☐ Front ☐ Behind ☐ Driver's side ☐ Passenger side ☐ N/A
Were you aware ☐, or surprised ☐, by the impact? **Did the airbags inflate?** ☐ Yes ☐ No
Describe what happened: _____
_____
_____
_____
Did the police come to the site? ☐ Yes ☐ No **Was a police report filed?** ☐ Yes ☐ No

Did any part of your body hit anything in the vehicle? ☐ Yes ☐ No
If yes, please describe: _____
Did the accident render you unconscious? ☐ Yes ☐ No **If yes, for how long?** _____
Describe how you felt immediately after the accident : _____
_____

Did you go to the hospital or see any other doctor? ☐ Yes ☐ No **By:** ☐ Ambulance ☐ Other
Where? _____ **When?** _____
Were x-rays taken? Of what body area? _____
Was medication prescribed? _____

Have missed any work since this injury? ☐ Yes ☐ No **Dates missed:** _____
Are your work activities restricted as a result of this injury? ☐ Yes ☐ No

Patient Name (print): _____ **Date:** _____

Patient Signature (or guardian signature for minor children): _____