Patient Name:				Today's Date:
Accident Date	Accident Time	Name of street or intersection	City	State

Number of Vehicles involved in the accident:

YOUR Vehicle Info:

Vehicle Year: Make & Model:

Area Damaged: Amount of damage: $

Your location in the vehicle (Circle one): Driver Front Passenger Rear Passenger

Who else was in your vehicle?

Speed of your vehicle just prior to impact:

Other Vehicle Info:

Type of Vehicle(s) (example: Sedan, Truck, Train, etc)

Areas Damaged:

Estimated Speed of other vehicle just prior to impact:

Were there additional vehicles involved? Yes no (add additional vehicles on back if applicable)

Please use the space below to draw a rough diagram of the collision:

Who has been determined to be "At Fault" for this accident?

Describe the impact (circle one) Mild Moderate Heavy

Describe your body position just prior to the impact? (example: twisted around looking at the kids in the back seat)

Were you wearing a seatbelt? Yes No If yes, were you able to unbuckle it afterwards? Yes No

Do you have any bruises, abrasions or cuts from this accident? Yes No

If Yes, please describe:

Did any parts of your body strike any part of the car? Yes no

If yes, please describe:

Did you lose consciousness? Yes No If yes, for approximately how long?

Did you go to the hospital? Yes No

If Yes: What tests were done (circle all that apply) MRI X-Ray Other_____

What prescription(s) were you given? _____

What recommendations were you given? _____

Is there anything else you wish to add? (use back of page if necessary)

Patient Signature: _____

Reviewed by Dr. Andrew Alvis D.C. _____

(Initials)