Brusveen
Chiropractic Clinic & Therapy

Auto Accident Information Form

Name:_____ Date of birth:_____

Date of accident:_____ Time of accident:_____

Where did the accident happen? (Road/ intersection) _____

Type of vehicle driven by you:_____ Type of other vehicle:_____

Please describe in detail what happened:

_____
_____
_____
_____
_____

Amount of damage to your vehicle: _____

Amount of damage to other vehicle:_____

Approximate speed of your vehicle:_____ Other vehicle speed:_____

Weather conditions: _____ Road conditions:_____ Visibility:_____

Was your vehicle pushed (Circle one) Forward backward sideways

Did your vehicle go into a spin or roll as result of the accident? Yes No

Were the breaks being applied? Yes No

Did the airbags deploy? Yes No

Was your ankle turned? Yes No

Did your head override the headrest? Yes No

What direction was your body thrown?: _____

Head position during impact? _____

Direction head was thrown:_____

Position of your head rest: _____

Body position during impact:_____

Were you wearing a seatbelt: Yes No

Did you hit anything inside the vehicle? Yes No

Did any part of your body hit the dashboard? Yes No

If yes, what hit the dashboard?_____

Did any part of your body hit the windshield? Yes No

If yes, What hit the windshield?_____

Did any part of your body hit the door? Yes No

If yes, what hit the door? _____

Did any part of your body hit a seat?

If yes, what hit the seat? _____

Did any part of your body hit the steering wheel? Yes No

If yes, what hit the steering wheel? _____

Did any part of your body hit the ceiling? Yes No

If yes, what hit the ceiling? _____

Did any part of your body hit any loose objects in the car? Yes No

If yes, what was impacted with loose objects? _____

Did any part of your body hit a side window? Yes No

If yes, what hit the side window? _____