Hawkins Chiropractic ~ Accident Information Form

Patient's Name: _____ **Today's Date:**_____

Name of Attorney/Firm: _____

Legal Assistant: _____ **Number** (_____)_____

Address: _____

Date of Accident:_____ **Time of Accident:**_____**AM / PM Daylight / Dusk / Dawn / Night**

Physical Location: On what **street(s)** _____

_____ and **city** _____ and **state** _____ was the accident?

Type of Road: 2-lane / 4-lane / highway / cement / brick / dirt / gravel / highway / tar

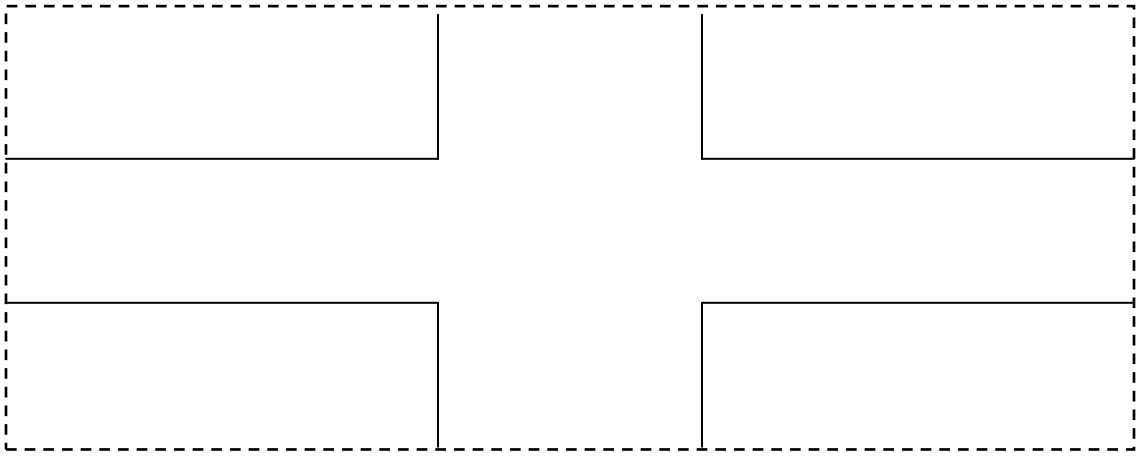
Location in Road: _____

Injury / Accident Description:

State how the accident happened in your own words:_____

_____

Please draw your accident here.



Injury / Accident Details:

Did the vehicle go off the road? Yes / No

Patient's **length of time** in the vehicle before accident? Hr(s)_____ Min(s)_____

Patient **body parts** struck during collision?_____

Patient **position**: Driver? Or Passenger- Front/ Back/ Right Side/ Left Side? _____

Patient **status** before accident: asleep / awake

Were you wearing a seat belt? Yes / No **Lap** or **Shoulder Harness**

Posted speed limit: _____mph

Rate of speed before impact: _____mph

Reports and Citation: To whom was the citation given and reason? _____

_____

Was an injury / accident report filed? Yes / No

Accident **reported to**: _____

Witness(es) of Accident: _____

Traffic Conditions: congested / good / heavy / normal / rush hour

Vehicle Information: Was the car hit from: Front? / Back? / Left Side? / Right Side?

Type of Vehicle: Make_____ Year_____

Vehicle Ownership: _____

Weather Conditions: foggy / icy / normal / poor visibility / raining / snowing / windy /_____

******Damage (Dollar Amount) done to your vehicle: $_____ The other vehicle: $_____**

Location taken after accident: home / hospital / emergency center / _____

Hospitalization status: Were you hospitalized for your injuries: Yes / No *Release Date:* _____

Which Hospital?: _____

Were you conscious after the accident: Yes / No

Additional health care provider(s): _____