RIVERSIDE CHIROPRACTIC CENTER
A Healthy Touch from Pediatrics to Geriatrics

Patient Auto Accident Form

We are truly sorry to hear that you have been in an accident. Please help us make sure you get the best possible care for your injuries by completing the questions below.

Legal Name: _____ Gender: Female / Male
Age: _____ Date of Birth: _____

Date, time, & place of accident: _____
Who did you report the accident to? _____
What type of vehicle were you in? _____ Approx. Speed? _____
What other vehicles were involved? _____Approx. Speed?_____
What damage was done to the vehicle? _____
Your position in the vehicle? _____ Did airbags deploy? Yes / No
Were you wearing seat belts? No / Yes Lap belt Shoulder harness Child Car seat

Were you treated by Emergency Medical Services? Yes / No
Did you go to the Hospital/ ER? Yes / No If yes, where? _____
What tests/exams were done? _____
What were the results? _____
What treatment was given? _____
Have you seen any other doctors for accident related injuries? Yes / No Who? _____
What was their diagnosis and treatment? _____

What pain or symptoms do you have as a result of the accident?_____
_____
When did you first notice the pain/symptoms? _____
What home care have you done? _____

Please explain how your accident happened below. Continue on back if needed.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Patient's signature: _____ Date: _____