Lawlor Chiropractic

CAR ACCIDENT REPORT

Name: ________________________ Date: ______________

Date of accident:__________ Time:____(am)(pm) Location:

Did your car strike the other car? ( ) Yes ( ) No
Did the other car strike your car? ( ) Yes ( ) No
Were you? ( ) Driver ( ) Passenger

Were you struck from? ( ) Behind ( ) Front ( ) Right ( ) Left

Were traffic citations issued to your car? ( ) Yes ( ) No
To the other car? ( ) Yes ( ) No

Were you wearing your seatbelt? ( ) Yes ( ) No

What position were you in at the time of impact?

Head:

Arms:

Feet:

List any new symptoms:

List old symptoms that are worse:

List old symptoms that were not effected by the accident:

Did you require post-accident hospitalization? ( ) Yes ( ) No
If yes, what care did you receive?

Have you lost any days from work? ( ) Yes ( ) No
Dates of loss: ___________________________Company:

Do you have an attorney? ( ) Yes ( ) No

Name:
Address:
Phone:

Name _____________________________________ Date

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