

Advantage Chiropractic & Rehabilitation  
13133 NW Military Hwy. #300  
San Antonio, TX 78231

**Auto Accident Form**

Patient Name: \_\_\_\_\_ Date of Accident: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

What type of vehicle were you in and what was your position in the vehicle?

\_\_\_\_\_

Owner's name of the vehicle you were traveling in? \_\_\_\_\_

Did the vehicle's airbags deploy? Y / N                      Were you wearing a seatbelt? Y / N

Amount of damage done to your vehicle: Mild / Moderate / Severe

Amount of damage to the other driver's vehicle: Mild / Moderate / Severe

*(If you have any pictures of the vehicles involved, please share them with the Dr.)*

Did you receive any medical attention at the scene of the accident or have you received any treatment for your symptoms since the accident? If yes, please provide the name of the facility and/or doctor's name, details of the evaluation, details of all treatment received, and the date(s) of all medical visits:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please describe the accident and include as many details as you can. (what happened?, approximate speed of all vehicles involved, point of impact of all vehicles involved):

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\_\_\_\_\_  
Patient Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_\_  
Date