ATLEE CHIROPRATIC CENTER
AUTO ACCIDENT QUESTIONAIRE

Name_____ Sex: M / F
Name of Auto Insurance Carrier_____
Agents name and telephone # _____
Attorney Name and telephone #_____
Date and Time of Accident _____
Were you the: Driver Front Passenger Rear Passenger
If a traffic violation was issued, to whom was it Issued? _____
Number of people in accident vehicle? _____
Did the police come to the accident site?…… YES NO
Was a police report filed? …… YES NO
Were there any witnesses?……... YES NO
Were you wearing your seat belt?…… YES NO
Was the vehicle equipped with airbags?…… YES NO
If yes, did it / they inflate?……. YES NO
In relation to the base of your skull, where was the headrest? ABOVE BELOW AT BASE OF SKULL
Did any part of your body strike anything in the vehicle? YES NO
If yes, please explain_____
Make and Model of the car you were occupying_____
Name of location / street on which you were occupying_____
What was the approximate speed of your vehicle?_____
Did the impact to your vehicle come from the: FRONT REAR LEFT SIDE RIGHT SIDE OTHER
During impact which way were you facing? FORWARD RIGHT LEFT
Were you aware or surprised by the impact?_____

In detail, please describe the accident:_____
_____
_____
_____

Please describe your symptoms in detail:_____
_____
_____

By my signature below I hereby authorize Atlee Chiropractic Center to release any medical records pertaining to my accident on _____

Signature_____ Date _____