VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Date _____

Patient Name _____

Date of Accident _____ Time of Accident _____ ☐ a.m ☐ p.m

Please describe the accident in your own words: _____

_____

_____

_____

Were you the: ☐ Driver ☐ Pedestrian ☐ Rear Passenger ☐ Front Passenger

How many people were in the accident vehicle? _____

ACCIDENT SITE

Road/Street Name _____

City/State _____

Nearest intersection, road/street _____

_____

Driving conditions ☐ Dry ☐ Wet ☐ Icy ☐ Other

Which direction were you headed? _____

Speed you were traveling? _____

VEHICLE

Make and Model of vehicle you were in: _____

_____

Were you wearing a seatbelt? ☐ Yes ☐ No

If yes, what type? ☐ Lap ☐ Chest

Was vehicle equiped with airbags? ☐ Yes ☐ No

If yes, did they inflate? ☐ Yes ☐ No

Did your seat have a headrest? ☐ Yes ☐ No

If yes, what was the position of the headrest?

☐ Low ☐ Midposition ☐ High

OTHER VEHICLE
(if applicable)

Make and model of other vehicle _____

Which direction was the other vehicle headed?

_____

Speed other vehicle was traveling _____

IMPACT

Did your car impact another vehicle? ☐ Yes ☐ No

Did your car impact a structure? ☐ Yes ☐ No

If yes, explain _____

_____

Did any part of your body strike anything in the vehicle?

☐ Yes ☐ No If yes, explain _____

Was impact from:

☐ Front ☐ Rear ☐ Left ☐ Right ☐ Other _____

At the time of impact were you:

☐ Looking straight ahead ☐ Looking to the right

☐ Looking to the left ☐ Looking down

☐ Looking up

Were both hands on the steering wheel? ☐ Yes ☐ N

If no, which hand was on the wheel? ☐ Right ☐ Le

Was your foot on the brake? ☐ Yes ☐ No

Were you: ☐ Surprised by impact ☐ Brace for impact

POLICE

Did the police come to the accident site? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Was there a violation issued? ☐ Yes ☐ No

If yes, to whom? _____

PATIENT CONDITION

Were you unconscious immediately after the accident? ☐ Yes ☐ No If yes, for how long_____

Please describe how you felt immediately after the accident: _____

_____

_____

_____

TREATMENT

Did you go to the hospital? ☐ Yes ☐ No

When did you go? ☐ Immediately after the accident ☐ Next day ☐ 2 or more days after the accident

How did you get to the hospital? ☐ Ambulance ☐ Private transportation ☐ Drove self

Name of hospital _____ Attending Physician _____

Diagnosis _____

_____

Treatment received _____

_____

List any x-rays taken_____

certify, to the best of my knowledge, that the above information is correct.

Sign X _____

Date X _____