

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 equipped 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 No

If no, which hand was on the wheel? Right Left

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 _____