

Vehicle Accident Information

Patient Information

Patient Name: _____ Date: _____

First Middle Last

Date of Accident: _____ Time of Accident: _____ AM PM

Please describe the accident in your own words _____

Were you the: Driver Front Passenger Pedestrian Rear Passenger: Right or Left

How Many people were in the accident? _____

Vehicle Information

Make, Model and Year of car you were in:

Were you wearing a seatbelt? Y N
If yes, which type? Shoulder Lap Both

Was the vehicle equipped with airbags? Y N
If yes, did they inflate properly? Y N

Did your seat have a headrest? Y N
If yes, what position were they in?
 Low Mid High

Accident Site

Road/Street name(s) _____

City _____ State _____

Nearest Intersection, Street names:

Speed you were traveling: _____ MPH

Which direction were you headed? _____

Driving Conditions:
 Dry Wet Icy Other

Police

Did the police come to the accident site? Y N

Were there any witnesses? Y N

Was a police report filled out? Y N

Was a traffic violation issued? Y N

To Whom? _____

Impact

Did your car impact another vehicle? Yes
 No a structure? Yes No other?
Yes No

If yes to any above, please explain:

Did you strike anything in the vehicle on impact? Yes No If yes, please specify

Where were you in the vehicle after the accident?

Was impact from: Front Rear Right Side
 Left Side Other, explain

At the time of impact were you looking:
 Straight Ahead To Left To Right
 Upwards Downwards

Were both hands on the steering wheel?
 Yes No If no, which hand was on the wheel? Right Left

Was your foot on the break? Yes No
Were you:
 Surprised by the impact
 Braced for the impact

Was you head thrown:
 Forward and backward Side to side

Other Vehicle (s)

How many vehicles were involved in the accident? _____

Make Model and Year of the other vehicle:

Did your vehicle strike one of the vehicles listed above? Yes No If yes, which one?

Did you strike the vehicle from: Right Side
 Left Side Front Rear

Which direction was the other vehicle heading?

North South East West

What was the approximate speed of the other vehicle(s) at impact? _____MPH

Draw the accident here to the best of your ability. List street names and vehicle locations. Alter the streets as necessary.

Comments: _____

Patient Condition

Were you unconscious immediately after the accident?

Yes No If yes, how long? _____

Please describe how you felt immediately after the accident:

Later that day:

The following day:

Before your injury, were you capable of working on an equal basis with others your age? Yes No

As a result of the accident is your home. or work activities restricted? Yes No If yes, please describe: _____

Do you notice any other restrictions as a result of the accident? Yes No If yes, please describe _____

Have you lost time from work as a result of the accident? Yes No If yes:

A. Last day worked: _____ How many work days have you missed? _____

B. Are you bring compensated for the time lost from work? Yes No

If yes, please state the type of compensation you are receiving: _____

Have you lost income as a result of the accident? Yes No

Did you have any previous illnesses, physical complaints or congenital problems from birth which would relate to your present symptoms? Yes No If yes, please describe _____

Treatment

Did you go to the hospital? Yes No How did you get to the hospital? Ambulance Private Transport.

When did you go to the hospital? Immediately Later that day Next day 2 days or more after

Name of hospital _____ Name of Doctor _____

Diagnosis _____

Treatment _____

X-rays taken? Yes No If yes, which area _____

Since this injury occurred, are you symptoms: Improving Getting Worse Same

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

Signature of Patient

Date

Printed Name of Patient

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