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?

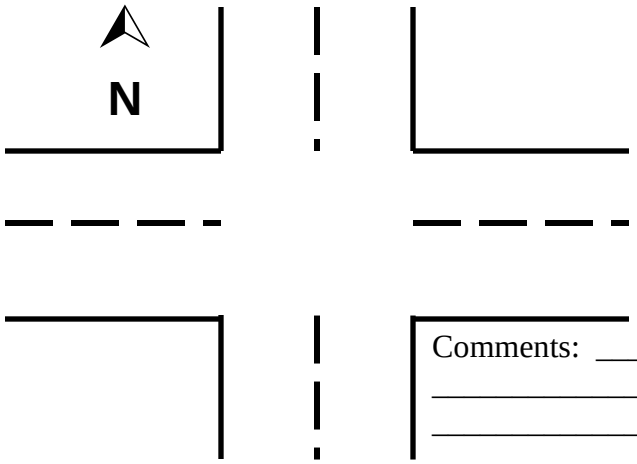
_____

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**

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 being compensated for the time lost from work? ❒ Yes ❒ No

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_____ _____

Signature of Patient **Date**

_____

Printed Name of Patient