MOTOR VEHICLE COLLISION INFORMATION

PATIENT INFORMATION

Today's Date _____

Patient's Name _____

Date of Collision _____ Time of Collision _____ [ ] a.m. [ ] p.m.

Description of the collision: _____

_____

_____

_____

Were you seated in the vehicle? [ ] yes [ ] no If yes, where? _____

How many people were in your vehicle? _____ Were you a pedestrian? [ ] yes [ ] no

COLLISION SITE

Street Name _____

City/State _____

Nearest Intersection _____

Conditions [ ] Dry [ ] Wet [ ] Icy [ ] Dark [ ] Clear [ ] Other _____

What direction were you going? _____

How fast was your car going? _____

YOUR VEHICLE

Year/Make/Model _____

Were you wearing a seatbelt? [ ] yes [ ] no

If yes, what type? [ ] lap belt [ ] shoulder harness [ ] both

Does your vehicle have an air bag? [ ] yes [ ] no

If yes, did it inflate properly? [ ] yes [ ] no

Did your seat have a headrest? [ ] yes [ ] no

If yes, what was it's position?

[ ] top of headrest even with the bottom of your head

[ ] top of headrest even with the middle of your head

[ ] Top of headrest even with the middle of your neck

IMPACT

Was your car involved in a collision with 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 _____

What type of impact? [ ] front [ ] rear [ ] left [ ] right [ ] other _____

What was the position of your body at the time of impact?

[ ] looking straight ahead [ ] looking to the right

[ ] looking to the left [ ] looking down

[ ] looking up [ ] looking back

Which hand(s) were on the steering wheel? [ ] left [ ] right [ ] both

Was your foot on the brake? [ ] yes [ ] no

If yes, which one? [ ] left [ ] right [ ] both

At the time of impact were you:

[ ] surprised by impact

[ ] braced for impact

OTHER VEHICLE

Year/Make/Model _____

Which direction was the other vehicle heading? _____

How fast was the other vehicle going? _____

POLICE

Did the police come to the collision site? [ ] yes [ ] no

Were there any witnesses? [ ] yes [ ] no

Was a police report filed? [ ] yes [ ] no

Were any tickets given? [ ] yes [ ] no If yes, to whom? _____

PATIENT'S CONDITION

Were you unconscious immediately after the collision? [ ] yes [ ] no If yes, for how long? _____

What best describes how you felt immediately after the collision? [ ] In shock [ ] Dazed, circumstances vague [ ] Other _____

_____

_____

TREATMENT

Did you go to the hospital? [ ] yes [ ] no If yes, when? [ ] immediately after the collision [ ] later that day [ ] the day after the collision [ ] two or more days after

How did you get to the hospital? [ ] ambulance [ ] private transportation

Hospital name _____ Doctor's Name _____

Diagnosis _____

Were x-rays taken? [ ] yes [ ] no If yes, of what area(s)? _____

What treatment did you receive? _____

_____

Were you give any home instructions? [ ] yes [ ] no If yes, what were they? _____

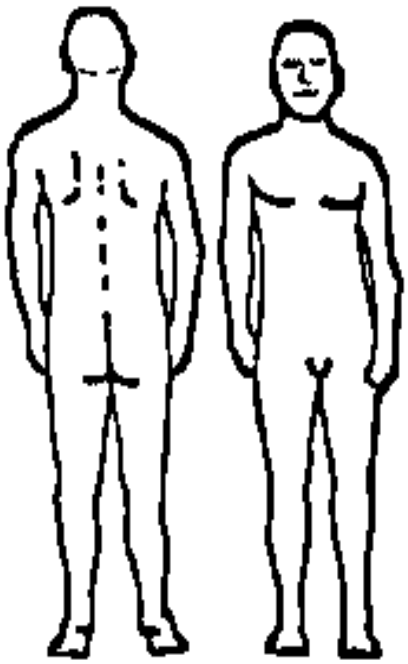
_____

SYMPTOMS/INJURIES

Have you been able to work since the injury? [ ] yes [ ] no If no, how many days of work have you missed? _____

Check any symptoms that you have had since the collision:

[ ] arm/shoulder pain	[ ] feet/toe numbness	[ ] neck pain
[ ] back pain	[ ] hand/finger numbness	[ ] neck stiffness
[ ] back stiffness	[ ] headaches	[ ] shortness of breath
[ ] chest pain	[ ] irritability	[ ] sleeping difficulty
[ ] dizziness	[ ] jaw problems	[ ] stomach upset
[ ] ear buzzing	[ ] leg pain	[ ] tension
[ ] ear ringing	[ ] memory loss	[ ] vision blurred
[ ] fatigue	[ ] nausea	



Is the condition getting worse? [ ] yes [ ] no [ ] not sure

Mark the areas on the picture where you are experiencing any symptoms

On the scale(s) below, rate the pain intensity and draw a line from the scale to the area on the picture.

none|——————————————————————————————|severe

none|——————————————————————————————|severe

none|——————————————————————————————|severe

none|——————————————————————————————|severe

What type of pain are you experiencing? [ ] sharp [ ] dull [ ] throbbing [ ] numbness [ ] aching

[ ] shooting [ ] burning [ ] tingling [ ] cramps [ ] stiffness [ ] swelling [ ] other _____

Which (if any) activities does the pain interfere with? [ ] work [ ] sleep [ ] daily routine [ ] recreational

Which activities or movements are painful? [ ] sitting [ ] standing [ ] walking [ ] bending [ ] lying down

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

Patient's Signature _____ Date _____