ANSWER THE FOLLOWING QUESTIONS IF YOUR WORK INJURY IS DUE TO A CAR ACCIDENT

Were you driving? □ Yes □ No Was it your car? □ Yes □ No If not, whose? _____

Were you the passenger? □ Yes □ No If yes, where were you seated in the car? □ Front □ Back □ Right Side □ Left Side

Were you alone at the time of the accident? □ Yes □ No If no, who else was in the car? _____

If others were in the car, were they injured? □ Yes □ No □ N/A Please explain: _____

What type of vehicle were you in? Make: _____ Year: _____

What damage was done to the car you were in? Inside: _____ Outside: _____

Other Damage: _____

What condition was your vehicle in prior to the accident? _____

What type of vehicle was the other involved in the accident? □ Car □ Truck □ SUV □ Motorcycle □ Other: _____

What damage was done to the other vehicle? Inside: _____ Outside: _____

Other Damage: _____

Do you have pictures of the involved vehicle? □ Yes □ No

At the time of the accident was it? □ Day □ Night □ Dusk □ Dawn What were the weather conditions? _____

How long had you been in the car? _____ What were the traffic conditions? _____

Where did the accident happen at? □ Stop Sign □ Traffic Light □ Intersection □ Highway □ Other _____

On what type of road did the accident occur? □ 2 Lane □ 4 Lane □ Gravel □ Other _____

Did your vehicle go off the road? □ Yes □ No If yes, explain: _____

Were you moving at the time of the accident? □ Yes □ No What was your speed? _____ What was the speed limit? _____

Was the involved party moving when the accident occurred? □ Yes □ No What was their speed? _____

Was your vehicle hit? □ Yes □ No Where? □ Front □ Back □ R Side □ L Side □ R Front □ L Front □ R Back □ L Back

Did your vehicle strike anything? □ Yes □ No If yes, what? □ Vehicle □ Sign □ Tree □ Guardrail □ Median □ Other_____

If you struck another vehicle, where did you hit them at? □ Front □ Back □ Right Side □ Left Side

Did you have your seatbelt on at the time of the accident? □ Yes □ No Shoulder harness on? □ Yes □ No

Was your seat reclined at the time of the accident? □ Yes □ No What was the position of the headrest? _____

Was your head turned at the time of the accident □ Yes □ No If Yes, what direction were you looking? _____

Did you hit part of your body during the collision? (Example: Head on Dash, Chest on Steering Wheel, Arm on Console, etc.)? □ Yes □ No

If yes, please list them all: _____

_____

_____

How did you feel after the collision? □ Stunned □ Disoriented □ Frightened □ Tightness □ Felt Mild Discomfort □ Felt Moderate Discomfort

□ Felt Severe Discomfort □ Felt Intense Pain □ Felt a Popping and Ripping Sensation □ Other _____

Were you completely conscious after the impact? □ Yes □ No Do you remember the impact? □ Yes □ No

Was an accident report made? □ Yes □ No With whom? Police of City _____ County _____ State _____

Who was cited for the accident? _____ For What? _____

Where did you go after the accident? _____

Were you hospitalized due to the accident? □ Yes □ No If yes, how long? _____ Hospital Name _____

Have you had any time loss from work? □ Yes □ No If yes, from _____ to _____

Have you ever had to have any outside help? □ Yes □ No If yes, what type? _____

My signature below indicates the above information is accurate and has been completed to the best of my knowledge.

Signature of Patient/or Guardian of said minor: _____ Date: _____