VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Date _____ Patient Number_____

Patient Name _____

Date of Accident _____ Time of Accident _____

Please describe the accident in your own words: _____

_____

_____

_____

Were you the ☐Driver ☐Front Passenger☐ Rear Passenger ☐Pedestrian

How many people were in the accident vehicle _____

Accident Site

Road/Street Name _____

City/State _____

Driving Condition ☐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 ☐Shoulder

Was vehicle equipped with airbags? ☐Yes ☐No

If yes did it/they inflate properly ☐Yes ☐No

Did your seat have a head support? ☐Yes ☐No

If yes, what was the position of the top of it

☐Low head ☐Mid head ☐Above head

Other Vehicle

Make and model_____

Which direction was vehicle headed? _____

Speed of vehicle _____

Impact

Did your vehicle impact other vehicle?

☐Yes ☐No

Did your vehicle 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

What was position of the head at the time of impact? _____

Which hand(s) was on the steering wheel?

☐Right ☐Left ☐Both ☐Neither

Was your foot on the brake? ☐Yes☐No

If yes, which foot☐Right ☐Left

Were you ☐surprised by impact

☐ Braced for impact

Police

Did the police come to the accident site?

☐Yes ☐No

Were there any witnesses? ☐Yes ☐No

Was a police report files? ☐Yes ☐No

Was a traffic violation issued? ☐Yes ☐No

If yes, to whom? _____