VEHICLE ACCIDENT INFORMATION

Date_____ Patient #_____

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

Airbags? If yes, did it 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 vehicle headed? _____

Speed of vehicle? _____

Agent Name_____

Phone # _____

Claim # _____

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 accident site? Yes No

Were there any witnesses? Yes No

Was a police report filed? Yes No

Was a traffic violation issued? Yes No

If Yes, to whom? _____