

VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Date _____

Patient Name _____

Date of Accident _____ Time of Accident _____ a.m.

p.m.

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 _____

Nearest intersection with road/street _____

Driving conditions Dry Wet Icy Other _____

Which direction were you headed? _____

Speed you were traveling? _____

IMPACT

Did your car impact 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 _____

Was impact from:

Front Rear Left Right Other _____

At the time of impact were you:

Looking straight ahead Looking to the right

Looking to the left Looking down

Looking up

Were both hands on the steering wheel? Yes No

If no, which hand was on the wheel? Right Left

Was your foot on the brake? Yes No

If yes, which foot was on the brake? Right Left

Were you: Surprised by impact Braced for impact

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 headrest? Yes No

If yes, what was the position of the headrest?

Low Midposition High

OTHER VEHICLE

(if applicable)

Make and model of other vehicle _____

Which direction was other vehicle headed? _____

Speed other vehicle was traveling _____

POLICE

Did the police come to the 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? _____