

Auto Accident Form

Name _____ Today's Date ____/____/____ Date of Accident ____/____/____

History of Occurrence

- Pedestrian Driver Passenger- Middle Front Passenger- Right Front
 Passenger- Left Rear Passenger- Center Rear Passenger -Right Rear

Patient Vehicle Type

- Compact Mid-size Full-Size SUV Pick-up Motorcycle Other _____

Second Vehicle Type

- Compact Mid-size Full-Size SUV Pick-up Motorcycle Other _____

Third Vehicle Type

- Compact Mid-size Full-Size SUV Pick-up Motorcycle Other _____

Road Conditions

- Dry Icy Wet Clear Foggy Dark Other _____

Road Type

- Concrete Asphalt Gravel Dirt Other _____

- Were you aware the accident was going to occur? Yes No. Were you wearing a seatbelt? Yes No
Did your airbag deploy? Yes No. Does your car have a head rest? Yes No.
What position was the head rest in? Up Middle Down
Head Position: Looking Straight Ahead Left Level Left Up Left Down
 Right Level Right Up Right Down Looking Up Looking Down

- Was your car braking? Yes No. Was your car moving? Yes No
If yes, how fast? (mph) <5 6-10 11-15 16-20 21-30 31-40 41-50 51-60 61-70 >70

- Was the second vehicle braking? Yes No. Was the second vehicle moving? Yes No
If yes, how fast? (mph) <5 6-10 11-15 16-20 21-30 31-40 41-50 51-60 61-70 >70

- Was the third vehicle braking? Yes No. Was the third vehicle moving? Yes No
If yes, how fast? (mph) <5 6-10 11-15 16-20 21-30 31-40 41-50 51-60 61-70 >70

Collision Details

First Impact: Hit By Another Vehicle Hit Another Vehicle Hit By An Object Hit An Object
(on the) Front Front-Right Front-Left Left Right Right-Rear Left-Rear Rear Top

Second Impact: Hit By Another Vehicle Hit Another Vehicle Hit By An Object Hit An Object
(on the) Front Front-Right Front-Left Left Right Right-Rear Left-Rear Rear Top

Collision Results

- Body was thrown: Backward Forward Left Right Can't Remember
Head Hit: Airbag Another Person's Body Back Of Front Seat Dashboard
 Front Windshield Rear-View Mirror Side Window/Door Steering Wheel
 Windshield

- Chest Hit:** Another Person's Body Back Of Front Seat Dashboard Side Window/Door
 Steering Wheel
- Shoulders Hit:** Another Person's Body Back Of Front Seat Shoulder Harness Side Window/Door
- Knees Hit:** Another Person's Body Back Of Front Seat Center Console Dashboard
 Door Panel Steering Wheel
- Hips Hit:** Another Person's Body Back Of Front Seat Center Console Dashboard
 Door Panel Steering Wheel

Vehicle Damage

- First Vehicle:** Totaled Significant Damage Light Damage No damage
Second Vehicle: Totaled Significant Damage Light Damage No damage
Third Vehicle: Totaled Significant Damage Light Damage No damage

Were you hospitalized? Yes No. If yes, please answer the questions in the paragraph below.

- When were you hospitalized?** Date _____ Immediately Later The Same Day The Next Day.
How were you transported to the hospital? Ambulance Life Flight Private Transportation
What did the hospital recommend? No Instructions See This Clinic See DC See Own Doctor
 See Neurologist See Orthopedist Over The Counter Medication Prescription Medication
 Other _____

Did you have any xrays taken? Yes No. If yes, what areas? _____

What are your current symptoms? Pain Numbness Stiffness Weakness

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