

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 x-rays taken? Yes No

If yes, what areas? _____

What are your current symptoms? Pain Numbness Stiffness Weakness

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