AUTO ACCIDENT INFORMATION

Patient Name _____ Date _____

1. Date of accident _____2. Time of Crash _____AM/PM

3. Please describe the crash:

_____

_____

4. Road/Street Name _____ 5. City_____

6. I was struck from:
□ Front
□ Rear
□ Left
□ Right

7.Other vehicle was:
□Bigger
□Smaller
□Same size as yours

8. I was the:
□ Driver
□ Front Passenger
□ Rear Passenger
□ Pedestrian

9. If struck from the rear, was your car pushed forward? (YES) (NO)

10. At time of impact, were you: Stopped Moving at steady speed Slowing down Gaining speed

11. Were you AWARE of the crash or CAUGHT BY SURPRISE?

12. Were you wearing a seatbelt? (YES) (NO)

13. Year, make and model of vehicle YOU were in: _____

14. Year, make and model of the OTHER vehicle: _____

15. Was your body facing straight ahead or turned at the time of the crash? _____

16. At time of impact, I was looking: Up Down Straight ahead To the right To the left

17. Lose consciousness? (Y) (N) 18. Were you dazed? (Y) (N) 19. Police arrive? (Y) (N)

20. Did any part of your body strike anything in the vehicle? If yes, explain: _____

21. Was any part of your vehicle damaged? _____22. Repair estimate (if known) _____

23. Did you go to a hospital? (Yes) (No) 24. How did you get to the hospital?

Where? _____ Ambulance Private Transportation

25. What did the hospital do for you?

_____ Exam _____ Given medication Other _____

_____ Given a prescription _____ X-rayed

26. When did you first notice the pain? Immediately after Several hours after The following day

27. List all doctors seen since the crash. _____

28. Have you been in a previous crash? (Yes) (No)