

# Auto Accident / Motor Vehicle Collision 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 headrest? Yes No

What position was the headrest 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

Were your brakes applied? 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

Were you wearing glasses? Yes No

Were you wearing a hat? Yes No

## Vehicle Damage

Your 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?

Did you have any other diagnostic imaging taken?

(such as CT, MRI)  Yes  No.

If yes, what areas?

What are your current symptoms?

Pain  Numbness  Stiffness  Weakness