



## Vehicle Accident Information

### Patient Information

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of Accident: \_\_\_\_\_ Time of Accident:  AM  PM \_\_\_\_\_

Please describe the accident: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Where were you sitting:  Driver  Front Passenger

Rear Passenger  Pedestrian

How many people were in the vehicle? \_\_\_\_\_ ( If applied)

### Location

Road/ Street Name: \_\_\_\_\_

City/State: \_\_\_\_\_

Road Conditions:  Dry  Wet  Icy  Fog  Other: \_\_\_\_\_

Which Direction Were you Headed? \_\_\_\_\_

Speed you were Traveling: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please continue to the next page



## Vehicle Accident Information

### Vehicle

Make/ Model: \_\_\_\_\_

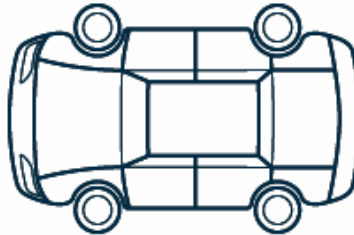
Were you wearing a seatbelt?  Yes  No

If Yes, What type:  Lap  Shoulder

Were Airbags inflate properly:  Yes  No

Position of your seat headrest:  Low  Midway  High  Other \_\_\_\_\_

Where were your Vehicle impact: ( Please mark in the diagram below)



Did your vehicle Impact another vehicle  Yes  No

If Yes: Model of other vehicle: \_\_\_\_\_ Direction of other vehicle: \_\_\_\_\_

Speed of other vehicle: \_\_\_\_\_

Did your vehicle impact a structure?  Yes  No

If Yes, Please explain: \_\_\_\_\_

Did any part of your body impact the vehicle ?  Yes  No

If Yes, Which part: \_\_\_\_\_

At the time of impact were you looking  To the right  To the left  Up  Down

Where you surprised by the impact?  Yes  No

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please continue to the next page



## Vehicle Accident Information

### Additional Information

Were Police at the accident site?  Yes  No  
Was a police report filed? ?  Yes  No  
Was a traffic violation issued?  Yes  No If Yes, To whom? \_\_\_\_\_

Were EMS personal at the accident site  Yes  No  
If Yes, where you treated at the accident site?  Yes  No  
Where you transfer to a medical facility?  Yes  No  
If Yes, Where you carried on a stretcher?  Yes  No  
According to EMS report were you fully concens?  Yes  No  
Were any X-Ray/ MRI/ CT taken?  Yes  No If Yes, To which body part \_\_\_\_\_  
What did it show: \_\_\_\_\_  
How long were you hospitalized? \_\_\_\_\_  
When were you discharged? (Date) \_\_\_\_\_  
Do you have the Hospital report?  Yes  No

Did you see another Physician for this current condition? ?  Yes  No  
If Yes, how long after the accident? \_\_\_\_\_  
What were you diagnosed with? \_\_\_\_\_

Did you see an Attorney ?  Yes  No  
If Yes, please provide the Attorney's Name and Contact information:  
\_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_