

If your injuries could be due to an AUTO ACCIDENT, please fill out this page.

Accident Patient History

Date of Accident: _____ Time _____

You were: Driver Front Passenger Rear Passenger Pedestrian

Description of Accident

What type of vehicle were you driving? Mid Size Full Size _____

Approximate speed of your automobile at time of impact was: _____ MPH

What happened first? A vehicle hit you Your vehicle hit another

How? From Behind On Right Rear Right Middle Right Front
 In Front On Left Front Left Middle Left Rear

Approximate speed of their automobile at time of impact was: _____ MPH

What portion of the other car first hit you or your car?

Behind Right Rear Right Middle Right Front
 Front Left Front Left Middle Left Rear

Were you wearing a Seat Belt? Yes No

Were you wearing a Shoulder Harness? Yes No

What position were your Vehicle Head Restraints? Highest Middle Lowest

Did your vehicle's Air Bag deploy? Yes No Not installed/activated

Did you see the accident coming? Yes No

You were: Forward Facing Looking Right Looking Left

Upon impact, you were thrown: Violently Gently

Which way was your body thrown? Right Left Forward Backward

After the moment of impact, your mental/emotional state was: Conscious
 Unconscious Confused

Did you receive medical attention immediately after the accident? Yes No

Where did you go immediately following the accident? Transported to _____ Hospital
 Was driven home Drove self home

Describe what part of your body struck any of the following vehicle parts or objects during the accident?

Dashboard Steering Wheel Left Door Right Door
 Rear View Mirror Seat Frame Windshield Other Person
 Unknown Object _____

If so, please describe:

