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Patient Name _____ Date _____

Date of Injury _____ ID# / DOB _____

B. Motor Vehicle Accident Information

1. Did the police arrive at the accident?
   ☐ Yes ☐ No

2. How was your vehicle hit?

   ☐ Rear end ☐ Head on ☐ Side swipe
   OR Did your vehicle hit another vehicle/object?
   ☐ Rear end ☐ Head on ☐ Side swipe

   If you were hit from behind, was your vehicle pushed forward upon impact?
   ☐ Yes ☐ No If yes, how much?
   _____

   Did your vehicle hit anything else after the initial impact?
   ☐ Yes ☐ No
   Explain _____
   _____

3. Were you at a stop or moving at the time of impact?
   ☐ Stopped ☐ Moving

   If you were stopped, was your foot on the brake?
   ☐ Yes ☐ No

   If you were moving, were you:
   ☐ Increasing speed
   ☐ Decreasing speed
   ☐ Traveling at a steady speed

   Was the other vehicle moving at the time of impact?
   ☐ Yes ☐ No

   If yes, was it: ☐ Increasing speed ☐ Decreasing speed
   ☐ Traveling at a steady speed

4. Where were you seated in the vehicle?
   _____
   _____

5. Which way was your head facing upon impact?
   _____
   _____

6. Were you aware of the approaching vehicle or did the impact catch you by surprise? ☐ Aware ☐ Surprise

7. Did you lose consciousness?
   ☐ Yes ☐ No

8. Were you wearing a seat belt? ☐ Yes ☐ No
   ☐ Lap belt ☐ Shoulder harness ☐ Both

9. Is your vehicle equipped with an airbag?
   ☐ Yes ☐ No

   Did it activate? ☐ Yes ☐ No

10. Is the top of your head rest:

    ☐ Above your head ☐ below your head
    Does your head touch the head rest?
    ☐ Yes ☐ No
    If no, how far in front of the head rest is your head?
    _____

11. What were the road conditions?
    ☐ Wet ☐ Dry ☐ Icy ☐ Oily

12. What type of vehicle were you in? (Make, model, year)
    _____
    What type of vehicle hit you? (Make, model, year)
    _____

13. Did any part of your body come into contact with the vehicle?
    ☐ Yes ☐ No
    Explain _____
    _____
    _____
    _____

    Did any parts of the vehicle break?? ☐ Yes ☐ No
    Explain _____
    _____
    _____
    _____

14. Check all of the following symptoms that you have experienced since the accident:
    ☐ Loss of memory _____
    ☐ Loss of balance _____
    ☐ Visual disturbances _____
    ☐ Hearing difficulties _____
    ☐ Difficulty breathing _____
    ☐ Sleep disturbances _____

15. Anything else you want to tell me about the accident or how you feel?
    _____
    _____
    _____

_____

Signature _____ Date _____