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MOTOR VEHICLE ACCIDENT

Date of Injury: Today's Date:

Name: Birth Date: Age: ☐ Male ☐ Female

Describe how the injury happened:

AUTOMOBILE ACCIDENT: Damage $

FRONT

REAR

O = Where patient sat

X = Where impact occurred

Were you the: ☐ Driver

☐ Passenger: ☐ Front ☐ Rear

Seat Belt: ☐ Yes ☐ No ☐ Lap ☐ Shoulder

Vehicle was: ☐ Moving ☐ At a stop

Vehicle Struck: ☐ Head-on ☐ Rear-ended

☐ Passenger side ☐ Driver side

During Impact: ☐ Brace w/arms ☐ Brace w/legs ☐ Steering wheel

☐ Dash ☐ Seat ☐ Floor ☐ Brakes ☐ Don't remember

Head: ☐ Straight Turned: ☐ Right ☐ Left ☐ Strike headrest

Strike any part of body: (Against what)

After collision: ☐ Lost consciousness? Minutes:

Did you feel? ☐ Nervous ☐ Stunned ☐ Scared ☐ Dizzy ☐ Disoriented

☐ Lightheaded ☐ Confused

Immediate symptoms:

Subsequent symptoms:

Evaluated by Paramedics? Taken to Hospital? Via ambulance?

Initial treatment:

Doctor's Name & Specialty:

Type of treatment:

Subsequent treatment: (including all Doctors and testing)

1

2

3

Was anyone in the vehicle with you?

CURRENT COMPLAINTS

1

2

3

PAST MEDICAL HISTORY

Prior injuries: Motor Vehicle:

Work:

Sports:

Other:

Major surgeries:

Hospitalizations:

Major illnesses: ☐ Hypertension ☐ Heart Disease ☐ Diabetes ☐ Ulcers ☐ Cancer

☐ Lung Conditions ☐ Kidney Problems ☐ Hernia ☐ Tuberculosis

☐ Other:

Family history of any of the above conditions? (Who/Which)

Is there any chance that you are pregnant at this time? ☐ Yes ☐ No

Allergies:

Current Medications:

Events of Accident in Patients Own Words