Accident Report

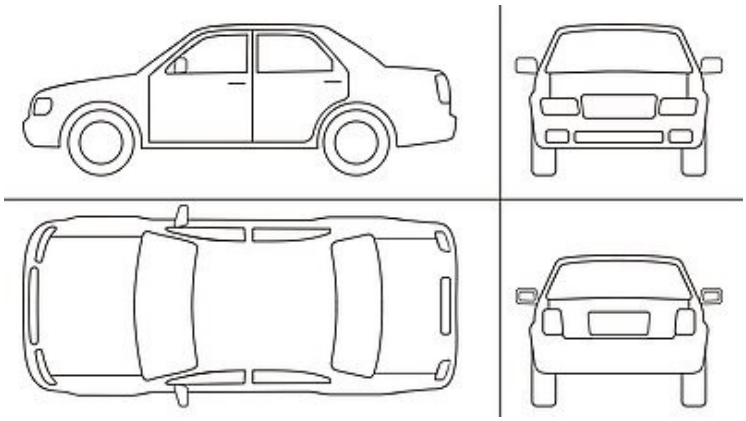
Patient Name : _____ Date of Accident : _____

☐ Driver ☐ Passenger (Front Seat/Back Seat) ☐ Pedestrian

Year/Make/Model of **YOUR VEHICLE** : _____

Year/Make/Model of **OTHER VEHICLE** : _____

Position of Vehicle : ☐ Stopped ☐ Proceeding Along ☐ Turning (Left or Right)



Location of Accident : _____ Time :_____ AM/PM

Visibility : ☐ Poor ☐ Fair ☐ Good Weather : ☐ Clear ☐ Rainy ☐ Windy ☐ Foggy

Whom Struck Whom? _____

Patient's Estimated Speed : _____ Other's Estimated Speed : _____

Was the Vehicle Driven Away or Towed Away ? : _____

Direction of Your Head : ☐ Forward ☐ Left ☐ Right

Who Received a Ticket? : ☐ Self ☐ Other Driver Returned to Work? ☐ Yes ☐ No ☐ Re-

Wearing Seatbelt?	☐ Yes ☐ No	Wearing Seatbelt?	☐ Yes ☐ No
Did the Airbags Deploy?	☐ Yes ☐ No	See the Accident Coming?	☐ Yes ☐ No
Braced for Impact?	☐ Yes ☐ No	Lose Consciousness?	☐ Yes ☐ No
Taken to Hospital?	☐ Yes ☐ No	Police Report Completed?	☐ Yes ☐ No

Have you Experienced any Additional Problems Since the Accident? _____

_____

Patient Signature : _____ Date : _____