Automobile Accident Details

Name:___________________________ Date ____/____/____

Date of accident: ____________, 20_______
Time of accident: ______________ AM or PM □ Dawn □ Daylight □ Dusk □ Night

Location (nearest intersection with road/street direction): _______________________________________
____
____

Accident description:____
____
____
____

Did the car go off the road?□ yes □ no Length of time you were in the car before accident: ____min/hrs
Body parts that were struck during the collision: ____
____

Your position in the car: □ driver □ passenger (which seat) □ front □ rear
Your status before the accident (may answer more than one): □ tired □ asleep □ awake
□ reclined in the seat □ rotated in the seat □ seat belt on □seat belt off □shoulder harness on
□shoulder harness off
What was the **posted speed limit**: _________mph; how fast were you traveling before impact: ____mph
Were **citations** given: □ yes □ no Reason citation was given: _____________________________________
Was an **accident/injury report** filed: □ yes □ no
Accident was reported to:____
Any witnesses?: □yes □no

Traffic conditions: □ normal □ good □ heavy □ congested □ rush-hour
Where was your vehicle impacted: □ front □ rear □ left side □ right side
Make model and year of your vehicle:____
Make model and year of the other vehicle: ____
Weather conditions: □ normal □ foggy □ icy □ poor visibility □ raining □ snowing □ windy

Location you were taken after the accident: □ home □ hospital □ emergency room □ minor emergency center □ other _____________
Were you hospitalized(admitted overnight or longer): □ yes □ no
What tests (ie. X-rays MRI etc.) and treatment (ie. drug surgery etc)did you receive: ______________
____

Functional Assessment
Have you notice limitations using your: □ neck □shoulders □arms □ hands □ back □ legs □ feet □ bowel/bladder □other__________________
Do you have pain when: □ lifting over _____lbs. □ sitting over ____min/ hrs. □ bending □ standing
□ walking □ climbing □ reaching □squatting □twisting □ crawling