Auto Accident Form

Name: ______________________ **Date:** ____________ **Date of Accident:** ______________

History of Occurrence **(Patient was located)**
○ Pedestrian ○ Driver ○ Passenger-Middle Front ○ Passenger-Right Front ○ Passenger-Left Rear
○ Passenger-Center Rear ○ Passenger- Right rear

Patient Vehicle Type:
○ Compact ○ Mid-Size ○ Full-Size ○ SUV ○ Pick-up ○ Van ○ Other: ____________________

Second Vehicle Type:
○ Compact ○ Mid-Size ○ Full-Size ○ SUV ○ Pick-up ○ Van ○ Other: ____________________

Third Vehicle Type:
○ Compact ○ Mid-Size ○ Full-Size ○ SUV ○ Pick-up ○ Van ○ Other: ____________________

Your rate of speed __________ **or** **Unknown**

Were you aware the accident was going to occur? ○ Yes ○ No

Were you wearing a seatbelt? ○ Yes ○ No

Did your airbags deploy? ○ Yes ○ No

Head Position: ○ Looking Straight Ahead ○ Left Level ○ Left up ○ Left Down ○ Right Level ○ Right up
○ Right Down ○ Looking Up ○ Looking Down

Collision Details:
First Impact: ○ Hit By Another Vehicle ○ Hit Another Vehicle ○ Hit By An Object ○ Hit An Object
ON THE- ○ Front ○ Front-Left ○ Front-Right ○ Left ○ Right ○ Right-Rear ○ Right-Front ○ Rear ○ Top

Second Impact: ○ Hit By Another Vehicle ○ Hit Another Vehicle ○ Hit By An Object ○ Hit An Object
ON THE- ○ Front ○ Front-Left ○ Front-Right ○ Left ○ Right ○ Right-Rear ○ Right-Front ○ Rear ○ Top

Collision Results:
Head Hit: ○ Airbag ○ Another Person's Body ○ Back of Front Seat ○ Dashboard ○ Front Windshield
○ Rear-View Mirror ○ Side Window/Door ○ Steering Wheel ○ Windshield ○ Headrest

Chest Hit: ○ Another Person's Body ○ Back of Front Seat ○ Dashboard ○ Side Window/Door
○ Steering Wheel ○ Airbag

Shoulders Hit: ○ Another Person's Body ○ Back of Front Seat ○ Shoulder Harness ○ Side Window/Door

Hips Hit: ○ Another Person's Body ○ Back of Front Seat ○ Center Console ○ Dashboard ○ Door Panel
○ Steering Wheel

Knees Hit: ○ Back of Front Seat ○ Center Console ○ Dashboard ○ Door ○ Steering Wheel

Did you receive care following the collision? ◯ Yes ◯ No

Where:____

When were you seen? ◯ Immediately ◯ Later the Same Day ◯ The Next Day

How were you transported? ◯ Ambulance ◯ Private Transportation

Did they take x-rays or give meds?
◯ RX Meds ◯ X-Rays

X-Rays Taken: What Areas: ____________________________________