Motor Vehicle Accident History Form

Name: ____ Today's Date: ________________

Date of Accident: ____________ Hour: ________ a.m./p.m. Location of accident (city): ____________________

Type of vehicles involved in accident (ie: car, truck, suv, etc.) ____________________________________

Were you the driver? Yes ☐ No ☐ If Passenger where seated? ______________________________

Were you wearing a seatbelt? Yes ☐ No ☐ Did it hold during the impact? Yes ☐ No ☐

Was there a headrest on your seat? Yes ☐ No ☐

Road conditions at the time of the accident: Wet ☐ Dry ☐ Icy ☐ Loose Gravel ☐ Other ☐ ____________

Visibility at the time of accident: Clear ☐ Cloudy ☐ Foggy ☐ Other ☐ __________________________

Were there any obstructions involved (example: blind corner, parked vehicle, etc)? ____________________

Did the police come to the accident scene? Yes ☐ No ☐ Who received a citation? __________________

For what reason was the citation given? ____

Did any person involved in the accident require an ambulance? Yes ☐ No ☐

Were you taken to the hospital? Yes ☐ No ☐ Hospital Name ______________________________

While at the hospital, what tests, x-rays, etc, were done? ______________________________________

Were you given any special instructions and/or medications? ____________________________________

During the Accident

Were you aware of the approaching collision or did it catch you by surprise? ___________________________

Did you have time to brace yourself? ____

What was the position of your body and head at impact (turned to the right / left / straight ahead, etc)?

____

What position were you in following the impact? ____

Were you trying to grab or restrain anyone? Explain ____

Was your foot on the brake? Yes ☐ No ☐ Was your car stopped or rolling? _______________________

If moving, estimated speed of your car ________ MPH The other vehicle(s) __________ MPH

Was your car slowing down, gaining speed, at a steady rate, etc? __________________________________

Did you lose consciousness (blackout) upon impact? Yes ☐ No ☐ If Yes, how long? ________________

Did you see stars, bright white lights, or did you feel a blinding or explosive sensation in your head? Yes ☐ No ☐

Were you struck from: Behind ☐ Right Side ☐ Left Side ☐ Front ☐ Other ☐ ____________________

Did your car strike the other(s) involved or did the other car strike yours? ____________________________

Please describe to the best of your ability what happened during this accident: _________________________

____

____

What bleeding cuts did you receive during the accident? ____

Were you thrown about inside the vehicle? Yes ☐ No ☐ On what part of the vehicle did the following body parts hit?

Head: ________________________ *Chest/Back:* ________________________________

Right/Left Shoulder: __________________ *Right/Left Knee:* ____________________________

Right/Left Hip: ______________________ *Right/Left ankle, foot:* _________________________

Right/Left arm, elbow, wrist, hand: ___________________ *Other:* ______________________

Did you have any broken bones? Yes ☐ No ☐ ____

Did any object in the car hit you? Yes ☐ No ☐ ____

What part of the vehicle broke during the accident? ____

Describe any pain or discomfort immediately following the accident: ______________________________

____

Describe any pain or discomfort later that same day: ____

____

Have you been in any previous auto accident(s)? List the year and briefly describe to what extent you were injured (in each accident) and how long you required care for those injuries: ______________________________

____

____

Please indicate if you have ever received care for similar injuries as those which you are currently seeking care for: _____

____

____

Are all of your symptoms (today) due to the motor vehicle accident, which you have described on page 1 of this form?
__________Yes __________No. If no, please list which symptoms are unrelated to this accident: ______________

____

____