AUTOMOBILE ACCIDENT

Patient Name_____

Today's Date_____

Date of Accident ___ / ___ / ___

Your Vehicle Was A ? Subcompact Compact Mid-Size Small Truck Full Truck
Van mini / full Tractor-Trailer Other_____

Other Car Was A ? Subcompact Compact Mid-Size Small Truck Full Truck
Van mini / full Tractor-Trailer Other_____

Where Was Your Car Struck ? Front Rear R-Side L-Side R-Front CornerL-Corner R-Back Corner L-Back Corner Other_____

Your Position IN The Car Was? Driver Passenger RR Passenger LR Passenger

Were The Brakes Applied At The Time Of Impact? Yes No Unknown

Did The Seat Break At The Time Of Impact Yes No Unknown

Were Your Seatbelts On At The Time Of Impact? Yes No Unknown

Did The Airbags Deploy At The Time Of Impact? Yes No

Where Did You Go After The Accident? Work Home Hospital Family Doctor Other_____

If You Sought Medical Care Where Did You Go?_____

If You Sought Medical Care, How Did You Get There? Self Friend Ambulance Helicopter

Did You Lose Consciousness At The Time Of The Accident? Yes No

Description Of Accident:_____

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Location Of Accident:_____

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Do You Have An Attorney? Yes No If Yes, Who_____