

Seat belts on? Yes No Shoulder harness on? Yes No Position of Headrest: _____

Was it? Daylight Night Dusk Dawn What were the weather conditions? _____

Were you tired? Yes No Were you awake? Yes No How long had you been in the car? _____

Where were you prior to the accident? _____

What were the traffic conditions? _____ What was the posted speed limit? _____

How fast were you going? _____ Type of road: 2 Lane 4 Lane Gravel Tar

Did it happen at a/an: stop sign traffic light intersection highway

Was your car hit? Front Back Left Side Right Side What damage was done to your car?

Inside: _____

Outside: _____

Other: _____

If you struck another car, did you strike it: Front Back Side What was the damage to the other car?

Inside: _____

Outside: _____

In what condition was the vehicle prior to the accident? _____

Do you have pictures of the involved automobile? Yes No What type of vehicle was involved in the accident?

Car Truck Motorcycle Other: _____ Size and Type: _____

Was accident report made? Yes No Police of: City: _____ County: _____ State: _____

Who was ticketed? _____ For what? _____

Did your vehicle strike anything? Yes No If yes, Another car Sign Tree Bridge Hedge

An Embankment Other: _____ Size and Type: _____

Were you completely conscious after the impact? Yes No

Do you remember the impact? Yes No Did your vehicle go off the road? Yes No

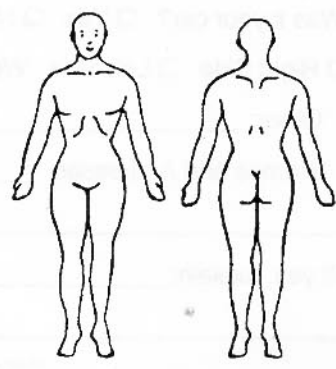
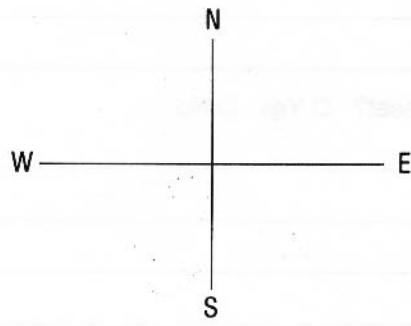
If so, Into a ditch? An Embankment? How Deep? _____

Does it bother you to ride in a car now? Yes No If so, as a Driver Passenger

State any strange events that happened during or immediately after the accident. _____

Have you had any time loss from work? Yes No If yes, from _____ to _____

Have you had to have any outside help? Yes No What type? _____



MARK PAIN AREA
+++ Burning
000 Stabbing
--- Sharp
||| Constant

PLEASE DRAW THE ACCIDENT

Patient Signature

Date

Staff Signature