

**Motor Vehicle Accident Patient History**

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

What State did the accident happen in? \_\_\_\_\_

1. Date of Accident: \_\_\_\_\_ 2. Time: \_\_\_\_\_ AM/PM

3. Driver of car: \_\_\_\_\_ 4. Where were you seated? \_\_\_\_\_

5. Who owns the car? \_\_\_\_\_ 6. Year/Model of car: \_\_\_\_\_

7. What was the approximate damage done to your car? \_\_\_\_\_

8. Visibility at time of accident: poor/fair/good/other: \_\_\_\_\_

9. Road conditions at time of accident: icy/rainy/wet/clear/dark/other: \_\_\_\_\_  
(describe) \_\_\_\_\_

10. Where was your car struck? Right/left/rear/front/side/other: \_\_\_\_\_  
(describe) \_\_\_\_\_

11. Type of accident: ( ) head-on collision ( ) broad side collision ( ) rear-end collision  
( ) front impact, rear-end car in front ( ) non collision: \_\_\_\_\_

12. Describe in your own words what happened to you upon impact:  
\_\_\_\_\_  
\_\_\_\_\_

13. Did you see the accident coming? YES/NO 14. Did you brace for impact? YES/NO

15. Were seat belts worn? YES/NO 16. Was a shoulder harness worn? YES/NO

17. Does your car have headrests? YES/NO

18. If yes, what was the position of those headrests compared to your head before the accident?

( ) top of headrest even with bottom of head

( ) top of headrest even with top of head

( ) top of headrest even with middle of neck

19. Was your car braking? YES/NO OR Stopped? YES/NO

20. Was your car moving at the time of the accident? YES/NO

21. If yes, how fast would you estimate you were going? \_\_\_\_\_ Mph

22. Head/Body position at time of impact:

( ) head turned left/right ( ) body straight in sitting position

( ) head looking back ( ) body rotated left/right

( ) head straight forward ( ) other: \_\_\_\_\_

23. At the time of accident, recall what parts of your head or body hit what parts on the inside of your car? \_\_\_\_\_

24. As a result of the accident you were: ( ) rendered unconscious ( ) dazed, circumstances vague  
( ) other: \_\_\_\_\_

25. Could you move all parts of your body following the trauma? YES/NO

26. If no, what parts and why? \_\_\_\_\_

27. Were you able to get out of the car and walk unaided? YES/NO

28. If no, why not? \_\_\_\_\_

29. Did you get bleeding cuts or bruises? YES/NO

30. If yes, what bleeding cuts did you get from this accident?  
\_\_\_\_\_

31. If yes, what bruises did you get from this accident?  
\_\_\_\_\_

32. Please describe how you felt:  
Immediately after the accident: \_\_\_\_\_

Later that day: \_\_\_\_\_

The next day: \_\_\_\_\_

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