MOTOR VEHICLE ACCIDENT

Fill out this page for *any* car accident in the patient's past history.

Patient Name:

Describe the accident:

Date or age: Time: Location:

Restraint: ❑ Seat belt and airbag ❑ Seat belt only ❑ Harness & Airbag ❑ Shoulder harness only ❑ Unrestrained ❑ Airbag only

Patient's location during the accident: ❑ Drivers seat ❑ Back left ❑ Front Passenger ❑ Back right ❑ Center front ❑ Center back ❑ Other:

	Patient's Vehicle	**Impacted Vehicle or object**
Type of Vehicle:	❑ Car ❑ Truck ❑ Other:	❑ Car ❑ Truck ❑ Other: _____
Primary Impact:	❑ Direct front ❑ Right door panel ❑ Front left ❑ Right front quarter ❑ Front right ❑ Right rear quarter ❑ Direct rear ❑ Left door panel ❑ Rear left ❑ Left Front quarter ❑ Rear right ❑ Left rear quarter	❑ Direct front ❑ Right door panel ❑ Front left ❑ Right front quarter ❑ Front right ❑ Right rear quarter ❑ Direct rear ❑ Left door panel ❑ Rear left ❑ Left Front quarter ❑ Rear right ❑ Left rear quarter
		Ditch Barrier Tree Other _____

Impact occurred when the other vehicle was: ❑ Stationary ❑ moving parallel to patient's vehicle ❑ moving from left to right ❑ moving from right to left ❑ Other:

Approximate Speed At The Time Of Impact: ❑ 1-5 mph ❑ 10 mph ❑ 15 mph ❑ 20 mph ❑ 25 mph ❑ 30 mph ❑ 40 mph ❑ 50 mph ❑ 60 mph ❑ 70 mph or more

Secondary Impact: ❑ Did not occur ❑ Rear vehicle ❑ Included rollover ❑ Front vehicle ❑ Left vehicle ❑ Right vehicle

Location of Trauma: ❑ No observable tissue injury ❑ Top head ❑ Forehead ❑ Back head ❑ Jaw ❑ Jaw joint ❑ Behind ear ❑ Ear ❑ Cheek ❑ Chin ❑ Nose ❑ Lips ❑ Teeth ❑ Tongue ❑ Neck ❑ Eyes ❑ Other:

Symptoms First Noted: ❑ Immediately ❑ Same day ❑ Next day ❑ One week ❑ One month ❑ Six months ❑ One year

Symptoms First Treated: ❑ Immediately ❑ Same day ❑ Next day ❑ One week ❑ One month ❑ Six months ❑ One year

First medical care received at:

❑ by attending ER doctor ❑ private physician ❑ Other:

List symptoms and description of injury: