

Auto Collision History (1/2)

Patient Name			Today's Date	
Date of collision	Time of collision	Time of Day <input type="checkbox"/> DAYLIGHT <input type="checkbox"/> DAWN <input type="checkbox"/> DUSK <input type="checkbox"/> DARK	City of Collision	
Street of collision			Road Conditions <input type="checkbox"/> DRY <input type="checkbox"/> DAMP <input type="checkbox"/> WET <input type="checkbox"/> SNOW <input type="checkbox"/> ICE <input type="checkbox"/> OTHER	
Where were you seated in the vehicle?		Name of driver		
Vehicle you were in (YEAR, MAKE, MODEL)		Other vehicle (YEAR, MAKE, MODEL)		
Your estimated speed at time of collision _____ MPH <input type="checkbox"/> STOPPED <input type="checkbox"/> SLOWING <input type="checkbox"/> ACCELERATING			Did this collision occur on-the-job? <input type="checkbox"/> YES <input type="checkbox"/> NO	

1. Was your vehicle equipped with headrests? Yes No Were the headrests: Up Down Don't know
Was the position of the headrest altered by the collision? Yes No Don't know
2. What was the approximate distance between the back of your head and the vehicle's headrest? _____ inches
3. Did your head go back over the top of the headrest? Yes No
4. Lap belt? Wearing Not wearing Shoulder belt? Wearing Not wearing Not available
5. Was the seat back adjustment altered by the crash? Yes No Was the seat broken? Yes No
6. Were you injured or bruised from the seat belt? Yes No
If Yes, please describe this injury _____
7. Does your vehicle have an airbag? Yes No Did the airbag deploy in this collision? Yes No
8. Did you sustain an injury from the airbag? Yes No
If Yes, please describe this injury _____
9. Were you aware of the approaching collision before impact, or were you caught by surprise? Aware Surprised
10. If your vehicle was stopped, was the brake applied? Yes No
11. Was your head pointed straight forward at the time of collision? Yes No
If No, how was your head positioned? _____
12. Was your body pointed straight forward at the time of collision? Yes No
If No, how was your body positioned? _____
13. If you were the driver during the collision, what was the position of your hands? One on wheel Two on wheel
14. Were you wearing a hat or glasses? Yes No If yes, were they still on after the collision? Yes No
15. Did any of your body parts strike any parts of the vehicle? Yes No Please describe:

More On Back

AUTO COLLISION HISTORY (2/2)

16. Did you lose consciousness (black out) upon impact? Yes No
What is the last thing you remember BEFORE the collision? _____
What is the first thing you remember AFTER the collision? _____
17. Do you remember the actual collision? Yes No
18. Did you experience a “ flash of light ” or “ explosion “ in you head? Yes No
19. Did you become? (please check all that apply)
 Confused Disoriented Light Headed Dizzy
 Nauseated Chilled Blurred vision Ring / Buzz in ear
20. Do you still have any of these symptoms? Yes No Which ones? _____
21. What bleeding cuts did you sustain during this collision? _____
22. What bruises did you sustain during this accident? _____
23. Did you go to a Hospital or Emergency Clinic? Yes No
If Yes, please provide name and city of hospital _____
How did you get to the hospital? _____
What parts of your body were x-rayed at the hospital? _____
How long did you stay at the hospital? _____
24. Did the Police come to the collision scene? Yes No Is there a Police Report for this collision? Yes No
25. What is the estimated cost damage to the vehicle you were in? \$ _____
26. Which of the following car parts broke during the collision? (please check all that apply)
 Windshield Front seat Back seat Steering wheel
 Right side window Left side window Headrest Other _____
27. Please give your best description of what happened during this collision:

Patient's Signature / Parent or Guardian Signature For Minor

Today's date