Auto Collision History (1/2)

Patient Name				Today's Date
Date of collision	Time of collision	Time of Day ☐ DAYLIGHT ☐ DAWN ☐ DUSK ☐ DARK		City of Collision
Street of collision			Road Conditions ☐ DRY ☐ DAMP ☐ WET ☐ SNOW ☐ ICE ☐ 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 ☐ STOPPED ☐ SLOWING ☐ ACCELERATING			Did this collision occur on-the-job? ☐ YES ☐ 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:

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____________________ ____________________

Patient's Signature / Parent or Guardian Signature For Minor **Today's date**