

Name _____ File# _____ Date _____

Auto accident

Description of Auto

Accident: _____

Were citations given? To who? For what?

Did the police come to the accident?

Was an accident report filled out?

What were the traffic conditions?

Were there any injuries reported at that time?

Was there any care given at the location of the accident?

Where did you go after the accident? How did you get there?

Were there any witnesses of the accident?

Where were, you driving?

What were you doing and where were you going?

What was the weather like?

What time of day was it.

What were you Driving? Year and make.

How fast were you going?

What part of the car was hit?

How ward were you hit?

How fast was the other car going?

What was the other vehicle?

Were you driving or were you a passenger?

Where were you in the car?

Were there more than two vehicles involved in the accident?

What were the road conditions?

What was the kind of road?

Were you aware that the accident was going to happen?

What were you doing at the time of the accident?

Were you wearing a seat belt?

Did the airbag deploy?

Does your car have a headrest?

Was it up and in the right position?

What was the position of your head at the time of the impact?

Was there more than one impact?

Did any part of your body hit the inside of the car? Please explain: _____

What was the vehicle damage?

Were you hospitalized?

When did you go to the hospital?

How did you go there?

What was done at the hospital?

Did you go to your doctor or another clinic after the accident?

What was recommended for you to do?

Were X-rays taken?

If yes, what areas of the body were the x-rays taken of?

Before the accident did you have any limitations, difficulties or pains with bending, lifting, sitting, standing or walking, or were all these activities normal for you before the accident?

After the accident, do you have any limitations, difficulties or pains with bending, lifting, sitting, standing or walking?

My current condition interferes with activities of daily living, normal lifestyle, and work activities.

Pain is aggravated by?

Pain is relieved by?

What care have you done for yourself? Ace wrap, compression, heat, ice, OTC medications, OTC Orthotics, OTC treatments, rest, soaking.

Status of symptoms? Getting worse, improving, remaining the same.

Draw a picture of how the accident Happened:

