PSMC Motor Vehicle Accident Form

Date of the accident:_________________________ Approximate time of the accident:___________

Your Vehicle

Make and model of your car/truck __________________________________ What is the year?_________________

Were you the: Driver Front Rt passenger Front middle passenger Rear passenger, driver's side

Rear passenger, Rt Side Rear middle passenger Other:_________________________

At the time of the accident what kind of surface were you driving on? Dry pavement Wet pavement Gravel Dirt Other:_____________

Were you restrained by a seatbelt? No Yes If yes, what kind? Shoulder & lap belts Shoulder only Lap only

Did your seat have a headrest? No Yes Where was the headrest positioned in relation to the top of your head?

Above my head Below my head Level with my head

Do you recall how far the headrest was from the back of your head? No 0-1 inches 1-3 inches 3 or more

The Other Vehicle(s)

How many vehicles struck your car/truck?_____________*If more than 1 please ask for another sheet of paper and

Answer the questions in this table for each vehicle*

What is the make & model of their car/truck? _________________ What is the year? ______________________

The Accident

Approximately how fast were you going at the time of impact? _______mph

How fast was the other car going at the time of impact?_______mph

If your car was standing still at the point of impact, where was your foot/feet?

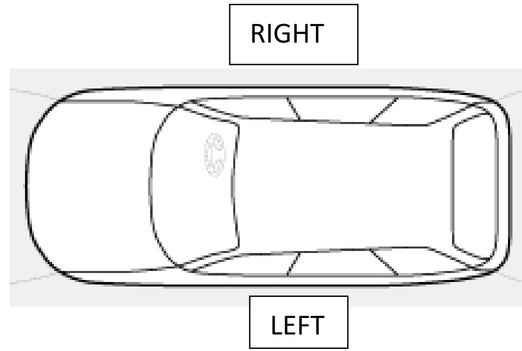
Pressed on the brake Resting on the brake Off the brake

Where was your head facing when the collision occurred?

Looking right at rearview mirror Looking right through a window Looking left through a window

Looking right through back window Looking up Looking down

On the diagram to the right please mark point(s) of impact on your vehicle.



Which direction did the striking vehicle come from?

Head on   From behind   From right   From left

Diagonal   Oblique

After the accident did you strike anything else? No   Yes   If yes, describe: ____

____

Was there any damage done to your vehicle? No   Yes   If yes, describe: ____

____

Was there any damage done to The other vehicle? No   Yes   If yes, describe: ____

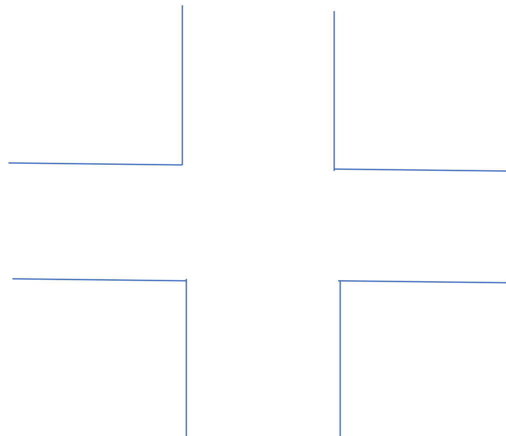
____

Did your airbags deploy? No   Yes   If yes, which airbags:____________________________________

Did the police arrive? No   Yes   If yes, was a report made? ________________________________

Your Accident in your words:

Below please describe in your words how the accident occurred. Please also use the diagram below to better explain if needed.



Injuries:

Were you aware of the collision as it occurred? No Yes

If yes, did you brace your arms and legs? No Yes

Did you lose consciousness at any point after the collision? No Yes

Were you ejected from the vehicle? No Yes If yes, describe: ______________________________________

Did any part of your body strike the interior of your vehicle? No Yes If yes, explain:________________________
____

Did you sustain any injuries outside of your vehicle? No Yes If yes, exlain:________________________________

____

Did you have any pain as a result of the collision? No Yes If yes, explain:_________________________________

____

Did you suffer any bruises, cuts, or broken bones from the collision? No Yes If yes, explain:_________________

____

Did you suffer any of the following symptoms (mark all that apply)? Dizziness Lightheadedness

Severe Headache Vertigo Blurry Vision Confusion Memory Loss Extreme Drowsiness Nausea

Vomiting Sensitivity to Light Difficulty concentrating Muscle Weakness Numbness/Tingling Ringing in Ears

Visual Disturbances Difficulty Sleeping Feelings of Depression or Sadness Feelings of Nervousness/Anxiety

Other:____

Medical History

Did you go to the hospital after the accident? No Yes If yes, please anser the questions below:

1) Did you tavel by: Ambulance Your Car Another Car
2) How long after the accident did you arrive at the hospital? _______________________________________
3) How did you leave the hospital? Someone drove me I drove myself
4) Were x-rays or other imaging procedure performed? No Yes If yes, explain: _____________________
5) Did you receive treatment or any prescriptions/medications at the hospital? No Yes If yes, explain:__
   ____

Other than the hospital, have you visited any other health care providers since the accident? No Yes If yes, explain (include names and phone numbers)____

____

Have you ever been involved in a motor vehicle accident before? No Yes If yes please answer the following:

1)When and where did the accidents occurr? A)____

B)____

2) Who did you see for care? A)____

B)____

3)What type of care did you receive? A)____

B)____

4) Did all of your symptoms resolve from the above mentioned accidents? No Yes If not, what smptoms persisted? ____

Did any remaining symptoms affect your daily activities in any way? No Yes If yes, explain:__________

____

Impact on Your Life:

Please mark the activities below that have been adversely affected, or are difficult to perform, since your motor vehicle accident.

General Movement Activities:

Movements requiring neck strength or motion

Movements requiring upper back strength or motion

Movements requiring mid back strength or motion

Movements requiring lower back strength or motion

Movements requiring hand strength or motion

Movements requiring wrist strength or motion

Movements requiring elbow strength or motion

Movements requiring shoulder strength or motion

Movements requiring hip strength or motion

Movements requiring knee strength or motion

Movements requiring ankle strength or motion

Movements requiring foot strength or motion

Patient’s Signature (or guardian’s signature)____________________________________ Date:_________________

Printed Name ____ Date:_________________