

**Auto Accident Injury Information**

What was your position in the vehicle?

- The driver                       The rear passenger  
 The front passenger       A pedestrian       Other: \_\_\_\_\_

What type of vehicle were you driving?

- Compact car     Full size car     Full size truck     Full size van  
 Mid size car     Compact truck     Mini van             Compact sport utility vehicle  
 Full size sport utility vehicle       Motorhome  
 Motorcycle                               Bicycle       Other: \_\_\_\_\_

What speed were you traveling at the time of the accident?

- Stopped at a stop light                       At a complete stop  
 Slowing down at an intersection             Moving slowly  
 Traveling at approximately \_\_\_ mph       Merging into traffic  
 Traveling faster than 65 mph               Other: \_\_\_\_\_

Who hit whom?

- Was struck by another vehicle       Struck a stationary object  
 Struck another vehicle                   Other: \_\_\_\_\_

What was your vehicle's point of impact?

- On the front       On the left front       On the rear       On the left rear  
 On the right front     On the middle front     On the right rear     On the middle rear  
 On the right side       On the rear right side       On the left side  
 On the front right side     On the middle right side     On the front left side  
 On the rear left side  
 On the middle left side     Other: \_\_\_\_\_

What speed was the other vehicle traveling?

- Stopped at a stop light                       At a complete stop  
 Slowing down for an intersection             Moving slowly  
 Merging into traffic                               Traveling faster than 65 mph  
 Traveling at approximately \_\_\_ mph               Other: \_\_\_\_\_

What was the other vehicle's point of impact?

- On the front       On the left front       On the rear  
 On the right front       On the middle front       On the right rear
- On the left rear       On the right side       On the rear right side  
 On the middle rear       On the front right side       On the middle right side
- On the left side       On the rear left side  
 On the front left side       On the middle left side       Other: \_\_\_\_\_

Were you wearing seat restraints?

- Was wearing a full lap and shoulder restraint       Was wearing a shoulder restraint  
 Was wearing a lap restraint       Was not wearing any seat restraints
- Other: \_\_\_\_\_

What position were your vehicle head rests in?

- Did have a head rest which was adjusted in the lowest position  
 Did have a head rest which was adjusted in the middle position
- Did have a head rest which was adjusted in the highest position  
 Was not equipped with a head rest
- Other: \_\_\_\_\_

Did your air bag deploy?

- Air bags were deployed       Other: \_\_\_\_\_  
 Air bags were not deployed

Were you prepared for the impact?

- Was completely surprised by the accident  
 Saw the collision coming and braced appropriately  
 Saw the collision coming       Other: \_\_\_\_\_

What position was your body in just prior to impact?

- A straight position       A position rotated to the left  
 A tilted forward position       A position rotated to the right

- A position that cannot be remembered
- Other: \_\_\_\_\_

What happened to your body the moment of impact?

- Body was tensed for impact
- Body whipped violently forward and backward
- Body was thrown from the vehicle
- Body was pinned in the vehicle
- Other: \_\_\_\_\_
- Body violently torqued and twisted
- Body was thrown over the seat
- Body was thrown violently from side to side
- Body was badly cut and bruised

What was your mental/emotional state immediately following the accident?

- Was not rendered unconscious by the impact of the accident
- Was not rendered unconscious but was shaken and disoriented
- Was not rendered unconscious but was shaken up
- Was not rendered unconscious but was disoriented
- Was rendered unconscious by the impact of the accident
- Other: \_\_\_\_\_

Did you receive medical attention at the scene of the accident?

- Did receive medical attention
- Did not receive medical attention
- Other: \_\_\_\_\_

Where did you go immediately following the accident?

- Was taken to the hospital
- Was taken to a personal physician
- Was taken home
- Was taken to this office
- Resumed activities
- Other: \_\_\_\_\_

**List each of your body parts that struck the following vehicle parts during the accident.**

**Dashboard:**

- Right side of the head
- Right arm
- Right wrist
- Right knee

- |  |                                      |                                     |                                      |
|--|--------------------------------------|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Right shoulder        | <input type="checkbox"/> Right elbow | <input type="checkbox"/> Right hip  | <input type="checkbox"/> Right ankle |
| <input type="checkbox"/> Left side of the head | <input type="checkbox"/> Left arm    | <input type="checkbox"/> Left wrist | <input type="checkbox"/> Left knee   |
| <input type="checkbox"/> Left shoulder         | <input type="checkbox"/> Left elbow  | <input type="checkbox"/> Left hip   | <input type="checkbox"/> Left ankle  |
| <input type="checkbox"/> Other: _____          |                                      |                                     |                                      |

**Windshield:**

- |   |                                      |                                      |                                      |
|---|--------------------------------------|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Right side of the head | <input type="checkbox"/> Right arm   | <input type="checkbox"/> Right wrist | <input type="checkbox"/> Right knee  |
| <input type="checkbox"/> Right shoulder         | <input type="checkbox"/> Right elbow | <input type="checkbox"/> Right hip   | <input type="checkbox"/> Right ankle |
| <input type="checkbox"/> Left side of the head  | <input type="checkbox"/> Left arm    | <input type="checkbox"/> Left wrist  | <input type="checkbox"/> Left knee   |
| <input type="checkbox"/> Left shoulder          | <input type="checkbox"/> Left elbow  | <input type="checkbox"/> Left hip    | <input type="checkbox"/> Left ankle  |
| <input type="checkbox"/> Other: _____           |                                      |                                      |                                      |

**Steering Wheel:**

- |   |                                      |                                      |                                      |
|---|--------------------------------------|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Right side of the head | <input type="checkbox"/> Right arm   | <input type="checkbox"/> Right wrist | <input type="checkbox"/> Right knee  |
| <input type="checkbox"/> Right shoulder         | <input type="checkbox"/> Right elbow | <input type="checkbox"/> Right hip   | <input type="checkbox"/> Right ankle |
| <input type="checkbox"/> Left side of the head  | <input type="checkbox"/> Left arm    | <input type="checkbox"/> Left wrist  | <input type="checkbox"/> Left knee   |
| <input type="checkbox"/> Left shoulder          | <input type="checkbox"/> Left elbow  | <input type="checkbox"/> Left hip    | <input type="checkbox"/> Left ankle  |
| <input type="checkbox"/> Other: _____           |                                      |                                      |                                      |

**Right Door:**

- |   |                                      |                                      |                                      |
|---|--------------------------------------|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Right side of the head | <input type="checkbox"/> Right arm   | <input type="checkbox"/> Right wrist | <input type="checkbox"/> Right knee  |
| <input type="checkbox"/> Right shoulder         | <input type="checkbox"/> Right elbow | <input type="checkbox"/> Right hip   | <input type="checkbox"/> Right ankle |
| <input type="checkbox"/> Left side of the head  | <input type="checkbox"/> Left arm    | <input type="checkbox"/> Left wrist  | <input type="checkbox"/> Left knee   |
| <input type="checkbox"/> Left shoulder          | <input type="checkbox"/> Left elbow  | <input type="checkbox"/> Left hip    | <input type="checkbox"/> Left ankle  |
| <input type="checkbox"/> Other: _____           |                                      |                                      |                                      |

**Left Door:**

- |   |                                      |                                      |                                      |
|---|--------------------------------------|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Right side of the head | <input type="checkbox"/> Right arm   | <input type="checkbox"/> Right wrist | <input type="checkbox"/> Right knee  |
| <input type="checkbox"/> Right shoulder         | <input type="checkbox"/> Right elbow | <input type="checkbox"/> Right hip   | <input type="checkbox"/> Right ankle |
| <input type="checkbox"/> Left side of the head  | <input type="checkbox"/> Left arm    | <input type="checkbox"/> Left wrist  | <input type="checkbox"/> Left knee   |
| <input type="checkbox"/> Left shoulder          | <input type="checkbox"/> Left elbow  | <input type="checkbox"/> Left hip    | <input type="checkbox"/> Left ankle  |
| <input type="checkbox"/> Other: _____           |                                      |                                      |                                      |

**Seat Frame:**

- |   |                                      |                                      |                                      |
|---|--------------------------------------|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Right side of the head | <input type="checkbox"/> Right arm   | <input type="checkbox"/> Right wrist | <input type="checkbox"/> Right knee  |
| <input type="checkbox"/> Right shoulder         | <input type="checkbox"/> Right elbow | <input type="checkbox"/> Right hip   | <input type="checkbox"/> Right ankle |
| <input type="checkbox"/> Left side of the head  | <input type="checkbox"/> Left arm    | <input type="checkbox"/> Left wrist  | <input type="checkbox"/> Left knee   |
| <input type="checkbox"/> Left shoulder          | <input type="checkbox"/> Left elbow  | <input type="checkbox"/> Left hip    | <input type="checkbox"/> Left ankle  |
| <input type="checkbox"/> Other: _____           |                                      |                                      |                                      |

**Unknown Object:**

- |   |                                      |                                      |                                      |
|---|--------------------------------------|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Right side of the head | <input type="checkbox"/> Right arm   | <input type="checkbox"/> Right wrist | <input type="checkbox"/> Right knee  |
| <input type="checkbox"/> Right shoulder         | <input type="checkbox"/> Right elbow | <input type="checkbox"/> Right hip   | <input type="checkbox"/> Right ankle |
| <input type="checkbox"/> Left side of the head  | <input type="checkbox"/> Left arm    | <input type="checkbox"/> Left wrist  | <input type="checkbox"/> Left knee   |
| <input type="checkbox"/> Left shoulder          | <input type="checkbox"/> Left elbow  | <input type="checkbox"/> Left hip    | <input type="checkbox"/> Left ankle  |
| <input type="checkbox"/> Other: _____           |                                      |                                      |                                      |