

- b. Vehicle Size:
 Subcompact Compact Mid-Size Full-Size
 Mini Light Other:
- c. How did this vehicle strike the vehicle you were in:
 Head on From Right From Left Rear Ended
 Sideswiped on Right Sideswiped on Left Other:
- d. What damage did this vehicle sustain:
 Minimal Moderate Extensive Totaled
 Unsure Other:

2. Second Vehicle to Strike Vehicle you were in:

- a. Vehicle Type:
 Car Van Station Wagon Pickup
 Truck Bus Other:
- b. Vehicle Size:
 Subcompact Compact Mid-Size Full-Size
 Mini Light Other:
- c. How did this vehicle strike the vehicle you were in?
 Head on From Right From Left Rear Ended
 Sideswiped on Right Sideswiped on Left Other:
- d. What damage did this vehicle sustain?
 Minimal Moderate Extensive Totaled
 Unsure Other:

3. Describe other vehicles to strike vehicle you were in:

Vehicle Type: How it struck:
 Vehicle Size: Damage:

4. Were traffic citations issued as result of accident:

No Citations Issued You Unsure
 Driver of other Vehicle Driver of vehicle you were in

D. CONDITIONS AT TIME OF ACCIDENT

1. What time of day did the accident occur?

Daylight Dawn Dusk Night
 Other:

2. What was the condition of the road?

Dry Damp Wet Snow Covered
 Icy Other:

3. Visibility:

- a. What was the visibility at impact:
 Good Fair Poor Other:
- b. If visibility was poor, why
 Sun Light Darkness Rain Snow
 Fog
 Traffic Other:

E. AT MOMENT OF IMPACT

1. Were you prepared for the accident:

Accident a complete surprise Aware of impending collision
 And braced for impact

2. Foot on Brake Pedal:

- a. Was your foot on brake pedal at impact: Yes No
 b. Was it knocked off pedal by impact: Yes No

3. Use of Restraints:

- a. Restraint Belts:
 - i. Were you wearing a restraint belt? Yes No
 - ii. What type of restraint belt were you wearing?
 Shoulder-lap Belt Shoulder Belt Lap Belt
- b. Headrest
 - i. Was vehicle equipped with headrest: Yes No
 - ii. What position was headrest in:
 Low Middle High Don't Know
- c. Airbags
 - i. Was vehicle equipped with air bags? Yes No
 - ii. Did the air bags deploy? Yes No
- d. Did you lose consciousness (black out) upon impact? Yes No
 - i. For how long? _____

4. Your Body

- a. What was your body position at impact:
 Straight Slouched Forward Rotated Right Rotated Left
 Don't Recall Other:
- b. What direction was your body thrown:
 Forward/Backward Backward/Forward Sideways
 Across Vehicle Outside Vehicle Under Vehicle
 Don't Recall Other:
- c. Did you receive any bleeding cuts? If so, where? _____

5. Your Head and Neck

- a. How far is the top of the headrest or backseat from the top of your head? _____ inches
Is this distance above or below the top of your head?
- a. What position were your head/neck in at impact?
 Straight Tilted Forward Rotated Right Rotated Left
 Don't Recall Other:
- b. Through what motion were your head/neck pitched?
 Forward/Backward Backward/Forward Sideways
 Don't Recall Other:

F. RESULT OF IMPACT

1. Which objects in the vehicle did the force of the collision cause your body to strike:

- a. Head
 - Steering Wheel Dashboard Windshield Right Side Door
 - Left Side Door Armrest Right Window Left Window
 - Headrest Ceiling Console Shift Lever
 - Front Seat Rear View Mirror Airbag Other:
- b. Right Upper Extremity (Arm)
 - Steering Wheel Dashboard Windshield Right Side Door
 - Left Side Door Armrest Right Window Left Window
 - Headrest Ceiling Console Shift Lever
 - Front Seat Rear View Mirror Airbag Other:

c. Left Upper Extremity (Arm)

- | | | | |
|---|---|---------------------------------------|--|
| <input type="checkbox"/> Steering Wheel | <input type="checkbox"/> Dashboard | <input type="checkbox"/> Windshield | <input type="checkbox"/> Right Side Door |
| <input type="checkbox"/> Left Side Door | <input type="checkbox"/> Armrest | <input type="checkbox"/> Right Window | <input type="checkbox"/> Left Window |
| <input type="checkbox"/> Headrest | <input type="checkbox"/> Ceiling | <input type="checkbox"/> Console | <input type="checkbox"/> Shift Lever |
| <input type="checkbox"/> Front Seat | <input type="checkbox"/> Rear View Mirror | <input type="checkbox"/> Airbag | <input type="checkbox"/> Other: |

d. Torso:

- | | | | |
|---|---|---------------------------------------|--|
| <input type="checkbox"/> Steering Wheel | <input type="checkbox"/> Dashboard | <input type="checkbox"/> Windshield | <input type="checkbox"/> Right Side Door |
| <input type="checkbox"/> Left Side Door | <input type="checkbox"/> Armrest | <input type="checkbox"/> Right Window | <input type="checkbox"/> Left Window |
| <input type="checkbox"/> Headrest | <input type="checkbox"/> Ceiling | <input type="checkbox"/> Console | <input type="checkbox"/> Shift Lever |
| <input type="checkbox"/> Front Seat | <input type="checkbox"/> Rear View Mirror | <input type="checkbox"/> Airbag | <input type="checkbox"/> Other: |

e. Right Lower Extremity (Leg)

- | | | | |
|---|---|---------------------------------------|--|
| <input type="checkbox"/> Steering Wheel | <input type="checkbox"/> Dashboard | <input type="checkbox"/> Windshield | <input type="checkbox"/> Right Side Door |
| <input type="checkbox"/> Left Side Door | <input type="checkbox"/> Armrest | <input type="checkbox"/> Right Window | <input type="checkbox"/> Left Window |
| <input type="checkbox"/> Headrest | <input type="checkbox"/> Ceiling | <input type="checkbox"/> Console | <input type="checkbox"/> Shift Lever |
| <input type="checkbox"/> Front Seat | <input type="checkbox"/> Rear View Mirror | <input type="checkbox"/> Airbag | <input type="checkbox"/> Other: |

f. Left Lower Extremity (Leg)

- | | | | |
|---|---|---------------------------------------|--|
| <input type="checkbox"/> Steering Wheel | <input type="checkbox"/> Dashboard | <input type="checkbox"/> Windshield | <input type="checkbox"/> Right Side Door |
| <input type="checkbox"/> Left Side Door | <input type="checkbox"/> Armrest | <input type="checkbox"/> Right Window | <input type="checkbox"/> Left Window |
| <input type="checkbox"/> Headrest | <input type="checkbox"/> Ceiling | <input type="checkbox"/> Console | <input type="checkbox"/> Shift Lever |
| <input type="checkbox"/> Front Seat | <input type="checkbox"/> Rear View Mirror | <input type="checkbox"/> Airbag | <input type="checkbox"/> Other: |

2. Did your body strike any other objects: _____

G. ADDITIONAL INFORMATION

1. In your own words please describe the accident. Were your moving or stopped? Etc.

Patient or Guardian Signature	Date
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