

Automobile Accident

Name: _____ Chart #: _____ Today's Date: _____ Accident Date: _____

DESCRIBE THE VEHICLE

Patient's Vehicle Type: <input type="checkbox"/> Bus <input type="checkbox"/> Van <input type="checkbox"/> Sport-utility <input type="checkbox"/> Sports car <input type="checkbox"/> Truck <input type="checkbox"/> Coupe <input type="checkbox"/> Station Wagon <input type="checkbox"/> Sedan <input type="checkbox"/> Pick-up truck	Vehicle Size: <input type="checkbox"/> Compact <input type="checkbox"/> Mini <input type="checkbox"/> Full-Size <input type="checkbox"/> Sub-compact <input type="checkbox"/> Light <input type="checkbox"/> Semi <input type="checkbox"/> Mid-Size	Position in vehicle: <input type="checkbox"/> Driver <input type="checkbox"/> Rear left passenger <input type="checkbox"/> Front mid passenger <input type="checkbox"/> Rear mid passenger <input type="checkbox"/> Front right passenger <input type="checkbox"/> Rear right passenger
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DESCRIBE THE ACCIDENT

Date of Accident: _____				
Action of patient vehicle: <input type="checkbox"/> Crossing intersection <input type="checkbox"/> Stopped at intersection <input type="checkbox"/> Stopped for pedestrian <input type="checkbox"/> Stopped in traffic <input type="checkbox"/> Turning right <input type="checkbox"/> Turning left <input type="checkbox"/> Traveling speed limit <input type="checkbox"/> Faster than speed limit <input type="checkbox"/> Slower than speed limit	Patient's Vehicle was hit: <input type="checkbox"/> Head-on <input type="checkbox"/> On the left front <input type="checkbox"/> On the right front <input type="checkbox"/> On the left rear <input type="checkbox"/> On the right rear <input type="checkbox"/> Was rear-ended <input type="checkbox"/> Sideswiped on left <input type="checkbox"/> Sideswiped on right	Patient's Vehicle hit: <input type="checkbox"/> Other vehicle head-on <input type="checkbox"/> Left front of other veh. <input type="checkbox"/> Left rear of other veh. <input type="checkbox"/> Rt rear of other veh. <input type="checkbox"/> Rt front of other veh. <input type="checkbox"/> Rear-ended other veh. <input type="checkbox"/> Sideswiped other veh on left <input type="checkbox"/> Sideswiped other veh on right	Damage: <input type="checkbox"/> Complete <input type="checkbox"/> Extensive <input type="checkbox"/> Minimal <input type="checkbox"/> Moderate	Time of Day: <input type="checkbox"/> Dawn <input type="checkbox"/> Daylight <input type="checkbox"/> Dusk <input type="checkbox"/> Night
			Damage to other Vehicle: <input type="checkbox"/> Complete <input type="checkbox"/> Extensive <input type="checkbox"/> Minimal <input type="checkbox"/> Moderate	Visibility <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Good
Patient's Vehicle was hit by: <input type="checkbox"/> A compact car <input type="checkbox"/> A pick-up truck <input type="checkbox"/> A full-sized car <input type="checkbox"/> A sport-utility veh. <input type="checkbox"/> A mid-sized car <input type="checkbox"/> A full-sized van <input type="checkbox"/> A subcompact car <input type="checkbox"/> A mini-van <input type="checkbox"/> A semi-trailer <input type="checkbox"/> None of the above <input type="checkbox"/> A light truck <input type="checkbox"/>	Patient's Vehicle hit: <input type="checkbox"/> A compact car <input type="checkbox"/> A pick-up truck <input type="checkbox"/> A full-sized car <input type="checkbox"/> A sport-utility veh. <input type="checkbox"/> A mid-sized car <input type="checkbox"/> A full-sized van <input type="checkbox"/> A subcompact car <input type="checkbox"/> A mini-van <input type="checkbox"/> A semi-trailer <input type="checkbox"/> None of the above <input type="checkbox"/> A light truck <input type="checkbox"/>	Weather Conditions: <input type="checkbox"/> Clear <input type="checkbox"/> Rainy <input type="checkbox"/> Cloudy <input type="checkbox"/> Snowing <input type="checkbox"/> Drizzling <input type="checkbox"/> Storming <input type="checkbox"/> Foggy <input type="checkbox"/> Sunny <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Road Conditions: <input type="checkbox"/> Dry <input type="checkbox"/> Damp <input type="checkbox"/> Wet <input type="checkbox"/> Iced over <input type="checkbox"/> Dry with icy patches <input type="checkbox"/> Snowed over	

DESCRIBE MOMENT OF IMPACT

Body Position at impact: <input type="checkbox"/> Leaning forward <input type="checkbox"/> Slouched in seat <input type="checkbox"/> Straight <input type="checkbox"/> Turned left <input type="checkbox"/> Turned right	Head Position at impact: <input type="checkbox"/> Straight <input type="checkbox"/> Tilted forward <input type="checkbox"/> Turned left <input type="checkbox"/> Turned right	Type of Passive Restraint: <input type="checkbox"/> Airbag <input type="checkbox"/> Lap belt <input type="checkbox"/> Shoulder belt <input type="checkbox"/> Shoulder-lap belt	Position of Headrests: <input type="checkbox"/> High position <input type="checkbox"/> Low position <input type="checkbox"/> Not installed	Did airbag deploy? <input type="checkbox"/> Deployed <input type="checkbox"/> Did not deploy
			Did you brace for impact? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Direction body was thrown: <input type="checkbox"/> Forward then back <input type="checkbox"/> To the right <input type="checkbox"/> Outside the vehicle			Direction head was thrown: <input type="checkbox"/> Back then forward <input type="checkbox"/> Forward then back <input type="checkbox"/> Side to side	

I understand that the information I have provided above is current and complete to the best of my knowledge.

Signature: _____