HISTORY OF MOTOR VEHICLE COLLISION (MVC)

Name_____

Today's Date_____

Date of Accident_____

Were police called to the scene? ☐ Yes ☐ No

Which Department?_____

Was a police report filed? ☐ Yes ☐ No

A ticket was issued: ☐ To me ☐ Other driver ☐ Neither

Did the crash occur while on the job? ☐ Yes ☐ No

BEFORE & DURING THE IMPACT

Were you the: ☐ Driver ☐ Passenger ☐ Rear Passenger

Was your seat: ☐ Slightly tilted ☐ Not tilted

Did your seat have a headrest: ☐ Yes ☐ No

The top of the headrest was: ☐ Below ☐ Even with

☐ Above the top of my head

What distance was between your head and the headrest:

☐ < 1 inch ☐ 1 - 2 inches ☐ > 2 inches

Were you restrained by: ☐ Lap belt ☐ Shoulder/Lap belt

☐ Air Bag ☐ I wasn't restrained

At impact, were you: ☐ Surprised ☐ Braced for it

At the time of impact, were you looking:

☐ Straight ahead ☐ To the left ☐ To the right

☐ Straight down ☐ Down & left ☐ Down & right

☐ Straight up ☐ Up & left ☐ Up & right

Were the brakes applied? ☐ Yes ☐ No

How many hands on the wheel? ☐ 1 ☐ 2 ☐ Neither

On impact, the seat: ☐ Bent ☐ Broke ☐ Neither

During the collision, what did your body hit:

☐ Nothing ☐ Windshield ☐ Steering Wheel

☐ Door ☐ Another body

During the crash, what body part struck something:

☐ Head ☐ Left Shoulder ☐ Right Shoulder

☐ Left Arm/Hand ☐ Right Arm/Hand

☐ Left Hip/Leg ☐ Right Hip/Leg

CONCERNING YOUR VEHICLE

Was the impact from?

☐ Front ☐ Rear ☐ Left ☐ Right

Make, Year & Model of vehicle you were in:

_____

Compared to your car, was the other vehicle:

☐ Bigger ☐ Smaller ☐ The same size

Was the road surface: ☐ Dry ☐ Wet ☐ Icy

☐ Pavement ☐ Gravel ☐ Dirt ☐ Mud

The collision moved your vehicle:

☐ a little ☐ more than a little ☐ a lot

Your vehicle was:

☐ Stopped ☐ Slowing ☐ Accelerating

How many other people were in your car?

CONCERNING THE TIME AFTER THE IMPACT

Were you: ☐ OK ☐ Confused ☐ In Pain

☐ Emotional ☐ Nauseated ☐ Had a Headache

Where did you go: ☐ Home ☐ Doctor ☐ Hospital

How did you leave the accident scene:

☐ Ambulance ☐ My car ☐ Another car

After the wreck, who did you see:

☐ No one ☐ Medical Doctor ☐ Chiropractor

As a result of this accident, are you:

☐ Taking Medication ☐ Not Taking Medication

Have you missed any work due to this accident?

☐ Yes ☐ No If yes, how many days?_____

Have you returned to work? ☐ Yes ☐ No

CONCERNING PREVIOUS ACCIDENTS

How many prior accidents involving cars? _____

How many accidents not involving cars? _____

Did you get hurt in those accidents? ☐ Yes ☐ No