Auto Accident Information

Today’s Date: _____/_____/_____
Name: _____________________________________________________

1.) Speed limit on the road where accident occurred: _____________________

2.) Estimated rate of speed upon impact: __________________________

3.) Traffic conditions:
   ☐ Congested       ☐ Good       ☐ Heavy       ☐ Normal       ☐ Rush Hour

4.) Vehicle make, year, and ownership: ________________________________

5.) Side of impact:
   ☐ Front       ☐ Rear       ☐ Left side       ☐ Right side

6.) Description of accident and road accident occurred on:
   __________________________________________________________________
   __________________________________________________________________
   __________________________________________________________________

7.) Did vehicle travel off road? ☐ No       ☐ Yes

8.) Weather conditions:
   ☐ Foggy       ☐ Normal       ☐ Poor visibility       ☐ Raining       ☐ Snowing       ☐ Windy

9.) Accident responded to? ☐ No       ☐ Yes; (please check all that apply)
   ☐ Ambulance       ☐ Police Department:______________       ☐ Fire Department       ☐ Other:______________

10.) Citation given to: ________________________________________________

11.) Was an injury/accident report filed? ☐ No       ☐ Yes

12.) Witness of accident: _____________________________________________

13.) Status before accident:
   ☐ Asleep       ☐ Awake       ☐ Shoulder Harness Off       ☐ Rotated in Seat       ☐ Seat Belt Off
   ☐ Seat Belt On       ☐ Tired       ☐ Shoulder Harness On       ☐ Reclined in Seat       ☐ Other: __________

14.) Body Parts Struck: _______________________________________________
Name: ________________________  Today’s Date: ________________________

15.) Patient Position:  □ Driver      □ Passenger:
    □ Front Middle Seat  □ Front Right Seat  □ Middle Left Seat  □ Middle Center Seat
    □ Middle Right Seat  □ Back Left Seat  □ Back Middle Seat  □ Back Right Seat

16.) Length of time in vehicle prior to accident: ________________________

17.) Capacities AFTER Accident:
    Bending:  □ Normal  □ Difficult  □ Limited  □ Painful
    Lifting:  □ Normal  □ Difficult  □ Limited  □ Painful
    Sitting:  □ Normal  □ Difficult  □ Limited  □ Painful
    Standing: □ Normal  □ Difficult  □ Limited  □ Painful
    Walking: □ Normal  □ Difficult  □ Limited  □ Painful

18.) Capacities BEFORE Accident:
    Bending:  □ Normal  □ Difficult  □ Limited  □ Painful
    Lifting:  □ Normal  □ Difficult  □ Limited  □ Painful
    Sitting:  □ Normal  □ Difficult  □ Limited  □ Painful
    Standing: □ Normal  □ Difficult  □ Limited  □ Painful
    Walking: □ Normal  □ Difficult  □ Limited  □ Painful

19.) Condition interferes with:
    □ Activities of Daily Living  □ Patient’s Normal Lifestyle  □ Patient’s Work Activities

20.) Were you hospitalized?  □ No  □ Yes; Where: ________________________

21.) Location taken after accident:
    □ Home
    □ Emergency Room; Where: ___________________________________________
    □ Minor Emergency Center; Where: _______________________________________
    □ Other: _____________________________________________________________

22.) After the accident, have you been able to do mental work?  □ No  □ Yes

23.) After the accident, have you been able to do physical work?  □ No  □ Yes

24.) Did you remain conscious after the accident?  □ No  □ Yes

25.) Do you remember the Impact?  □ No  □ Yes

26.) Have you lost time from work?  □ No  □ Yes; List From and To dates:____________

27.) Are you limited in movement?  □ No  □ Yes

28.) Is riding in a car bothersome?  □ No  □ Yes

29.) Have you received outside help for household tasks or personal care?  □ No  □ Yes

30.) Time of accident:
    □ Dawn  □ Daylight  □ Dusk  □ Night

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