

## COLLISION INFORMATION

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Where did the collision occur: Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Date when the collision occurred: \_\_\_\_\_ AM or PM. Was the road:  Dry  Wet  Snowy  Icy

Were you the  Driver  Front middle passenger  Front right passenger  
 Back left passenger  Back middle passenger  Back right passenger

Describe what happened: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## CRASH DETAILS

- Yes  No If driving, were both hands on the wheel at impact?  
 Yes  No If passenger, did your hands brace yourself?  
 Yes  No Did you have your seat belt and shoulder strap on?  
 Yes  No Was your seat up at the time of impact?  
 Yes  No Were you wearing a bulky coat or slippery pants?  
 Yes  No Did the seat belt engage?  
 Yes  No Did you hit the dash, steering wheel or window?  
 Yes  No Did you know you were going to be hit?  
 Yes  No Did you brace your self with hands or feet?  
 Yes  No If driving, was your foot on the brake at impact?  
 Yes  No Was your head turned at impact?  
 Yes  No Were you leaning forward?  
 Yes  No Did your glasses fly-off at impact?  
 Yes  No Was your body turned at the moment of impact?  
 Yes  No Did you get hit into another car, tree, railing, etc?  
 Yes  No Any damage or marks on your vehicle, the vehicle that hit you, or another object that was hit?  
What part of the vehicle was hit? \_\_\_\_\_

1. What make and model of vehicle were you in? \_\_\_\_\_ The other vehicle? \_\_\_\_\_

2. What kind of seat were you in?  Bucket  Bench  Fabric  Leather

3. Did the car have headrests?  Yes  No

4. Did you hit your head on the headrest?  Yes  No On the back window if in a small truck?  Yes  No

5. Was the headrest positioned:  below  level with  above the center of your head

6. Did your head hurt after the collision  Yes  No Did your TMJ/jaw hurt after the collision?  Yes  No

7. How soon after the collision did you notice any pain? \_\_\_\_\_

8. Did the crash affect:

- dizziness  memory  concentration  headaches  balance  nightmares  breathing  
 fatigue  irritability  ability to read  ability to listen  appetite  nausea  vision

9. Is there anything else you want us to know? \_\_\_\_\_  
\_\_\_\_\_