ANDRESEN ACTIVE HEALTHCARE

Motor Vehicle Accident

1. Description of Accident:____

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2. Your Vehicle Type: () Car () Van () Station Wagon () Pickup truck
   () Large Truck () Bus
3. Your Position in vehicle: () Driver () Passenger () Left rear Passenger
   () Right Rear Passenger
4. What was your vehicle doing at the time of accident? () Stopped at intersection
   () Parking () Stopped in traffic () Stopped at light () Making a right turn
   () making a left turn () Accelerating () Slowing down () Other__________
5. Time of accident: ______________________
6. Your vehicle speed:____________________ Their vehicle speed:__________
7. Damage to your vehicle: () Mild () Moderate () Totaled Est. damage?_________
8. Damage to their vehicle: () Mild () Moderate () Totaled Est. damage?_________
9. Visibility at time of accident: () Poor () Fair () Good
10. Road condition at time of accident? () Icy () Wet () Sandy () Dark () Clean/Dry
11. Did you hit other vehicle? () Yes () No
12. Did other vehicle hit you? () Yes () No
13. Did you hit another object? () Yes ______________ () No
14. Point of Impact: () Head-On () Left Front () Right Front () Rear-End
    () Left Rear () Right Rear
15. Did you see the accident coming? () Yes () No
16. Were you braced for the impact? () Yes () No
17. Did you have a seat belt on? () Yes () No
18. Did you have a shoulder harness on? () Yes () No
19. Does your vehicle have headrests? () Yes () No
20. What was the position of your headrest at the time of impact?
    () Even with top of head () Even with bottom of head () Middle of neck
21. What was the position of your head during the impact? () Facing straight forward
    () Turned Right () Turned Left

During the Accident . . .

22. Did your body strike the inside of your vehicle? () Yes________________() No
23. Did you lose consciousness? () Yes (How long?) ___________________ () No
24. Did the police show up at the scene? () Yes () No
25. Was an accident report filled out? () Yes () No