Accident/Injury Form

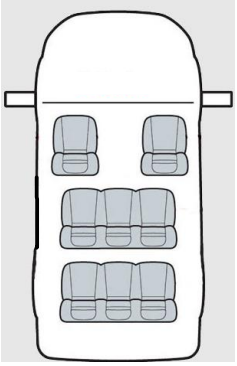
Date of Injury _____

Was an injury/accident report filed? ☐ Yes ☐ No

Where did you go after the incident? ☐ Home ☐ Work ☐ Hospital/acute care

Circle where you were seated in the vehicle:

**If the vehicle doesn't have a middle row only use the first 2 sections of the diagram*



The vehicle was impacted on the:

☐ Front

☐ Left Side

☐ Right Side

☐ Rear

Did you have any symptoms prior to this injury?

☐ Yes ☐ No

Were you wearing a seatbelt? ☐ Yes ☐ No Did the airbag deploy? ☐ Yes ☐ No

Make, model of your vehicle _____ ☐ unknown – – ☐ small vehicle ☐ large vehicle

Make, model of their vehicle _____ ☐ unknown – – ☐ larger/heavier than yours

Your speed was: _____ ☐ unknown Their speed was: _____ ☐ unknown

Loss of consciousness: ☐ Did not lose consciousness ☐ Lost consciousness ☐ unknown

The headrest was: ☐ N/A ☐ middle ☐ low Were you surprised by impact? ☐ Yes ☐ No

Was your head rotated/inclined? ☐ left ☐ right ☐ inclined Did you feel pain immediately? ☐ Yes ☐ No

SEE REVERSE SIDE

WHOLE BODY
HEALTH CARE

Duties Under Duress:

Work ☐ Lifting ☐ Bending ☐ Sitting ☐ Walking ☐ Computer ☐ Other _____
Studies/school ☐ Lifting ☐ Bending ☐ Sitting ☐ Walking ☐ Computer ☐ Studying ☐ Other _____
Domestic ☐ Vacuuming ☐ Childcare ☐ Cleaning ☐ Preparing meals ☐ Other _____
Household ☐ Yard work ☐ Transportation ☐ Shopping ☐ Taking out trash ☐ Other _____

Loss of Enjoyment:

Work ☐ Lifting ☐ Bending ☐ Sitting ☐ Walking ☐ Computer ☐ Other _____
Studies/school ☐ Lifting ☐ Bending ☐ Sitting ☐ Walking ☐ Computer ☐ Studying ☐ Other _____
Domestic ☐ Vacuuming ☐ Childcare ☐ Cleaning ☐ Preparing meals ☐ Other _____
Household ☐ Yard work ☐ Transportation ☐ Shopping ☐ Taking out trash ☐ Other _____
Sports ☐ Social ☐ Competitive ☐ Regional ☐ Other _____

Describe the event: