

MONTVALE HEALTH ASSOCIATES  
MOTOR VEHICLE ACCIDENT

**Driving Role**

- A passenger in the back seat
- A passenger in the front seat
- Driver of a motorcycle
- The driver with both hands on the wheel
- The driver with left hand on the wheel
- The driver with right hand on the wheel
- Other

Patient Name: \_\_\_\_\_

Date of Accident: \_\_\_\_\_

**Vehicle Status**

- Accelerating
- At a stop light
- Attempting to stop
- Changing lanes
- Driving down the road
- Driving in a parking lot
- Moving
- Moving at a moderate speed
- Moving at speed limit
- Moving in reverse
- Sliding out of control (weather related)
- Slowing down
- Speeding
- Spinning out of control (weather related)
- Stopped
- Turning

**Impact Area**

- Driver side
- Front bumper
- Front driver side corner
- Front passenger corner
- Passenger side
- Rear bumper
- Rear driver side corner
- Rear passenger side corner
- Rear trailer
- Totaled and head on collision

**Lighting Conditions**

- Dawn
- Dusk
- Full Daylight
- Night

**Road Conditions**

- Dry
- Damp
- Ice covered
- Nasty
- Snow covered
- Wet

**Visibility**

- Excellent
- Good
- Fair
- Poor

**Opposing Vehicle Type**

- Compact car
- Full size car
- Large pickup truck
- Large SUV
- Motorcycle
- Semi
- Small SUV
- Other

**Bracing Status**

- I was able to brace for impact with my (hands, feet, knees)
- I was aware that the accident was impending, but unable to brace
- I was not aware that the accident was impending

**Opposing Vehicle Speed** \_\_\_\_\_

**Vehicle Speed** \_\_\_\_\_

**Headrest Position**

- High
- Low
- Middle
- Unknown

**Admitted** \_\_\_\_\_

**Admission Time**

- At time of the accident
- At a later time

**Transportation to the hospital**

- Ambulance
- Life Flight
- Police car
- Private transportation

**Hospital/Doctor** \_\_\_\_\_

**Hospitalized days** \_\_\_\_\_

**Problems**

- Brightness
- Darkness
- Fog
- Rain
- Snow
- Traffic

**Injury Location**

- |                                       |  |  |  |   |   |
|---------------------------------------|--|--|--|---|---|
| <input type="checkbox"/> Back of face | <input type="checkbox"/> Back of head  | <input type="checkbox"/> Back of neck  | <input type="checkbox"/> Chest         | <input type="checkbox"/> Fingers on the left hand | <input type="checkbox"/> Finger on the right hand |
| <input type="checkbox"/> Forehead     | <input type="checkbox"/> Front of face | <input type="checkbox"/> Front of head | <input type="checkbox"/> Front of neck | <input type="checkbox"/> Left arm                 | <input type="checkbox"/> Left elbow               |
| <input type="checkbox"/> Left hand    | <input type="checkbox"/> Left hip      | <input type="checkbox"/> Left knee     | <input type="checkbox"/> Left leg      | <input type="checkbox"/> Left shin                | <input type="checkbox"/> Left shoulder            |
| <input type="checkbox"/> Left wrist   | <input type="checkbox"/> Low back      | <input type="checkbox"/> Mid back      | <input type="checkbox"/> Nose          | <input type="checkbox"/> Right arm                | <input type="checkbox"/> Right elbow              |
| <input type="checkbox"/> Right hand   | <input type="checkbox"/> Right hip     | <input type="checkbox"/> Right knee    | <input type="checkbox"/> Right leg     | <input type="checkbox"/> Right shin               | <input type="checkbox"/> Right shoulder           |
| <input type="checkbox"/> Right wrist  | <input type="checkbox"/> Side of face  | <input type="checkbox"/> Side of head  | <input type="checkbox"/> Side of neck  | <input type="checkbox"/> Upper back               |   |