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MOTOR VEHICLE ACCIDENT FORM

PATIENT'S NAME ____
AGE________________________________

DATE OF ACCIDENT ____ OCCUPATION _______________________

DOMINANT HAND ___________________(R) ______________________ (L)

TYPE OF VEHICLE YOU WERE IN ____

YOUR POSITION IN THE _________________ DRIVER _________________FRONT SEAT _________________BACK SEAT

**IF ANOTHER VEHICLE WAS INVOLVED – WHAT TYPE? ____

WERE YOU STRUCK IN THE ___________REAR ____________FRONT ____________RIGHT SIDE ____________ LEFT SIDE

WERE YOU WEARING A SEAT BELT? ___________ YES ______________ NO

DID YOU STRIKE ANY PARTS OF YOUR BODY AT IMPACT? PLEASE EXPLAIN:

DID YOU LOSE CONSCIOUSNESS? _____________ YES ______________ NO

WHAT HOSPITAL WERE YOU TAKEN IF ANY? ____

WERE YOU ADMITTED TO A HOSPITAL? __________________ YES ______________________NO

IF YES – DATE OF ADDMISSION ______________________________ DATE OF DISCHARGE ______________________________

BRIEFLY LIST AREAS OF PRESENT PAIN, NUMBNESS OR WEAKNESS: