UCR Health Centers
AUTOMOBILE ACCIDENT DETAILS

Patient Name_____ Today's Date: _____

Date Accident Occurred_____

Your vehicle?: Subcompact Compact Mid-size Full-size sm/truck
full truck mini-van tractor trailer
Other:_____

Other vehicle?: Subcompact Compact Mid-size Full-size sm/truck
full truck mini-van tractor trailer
Other:_____

Location your car was struck is: Front Rear R-Side L-side R-Front Corner
L-Front Corner R-Back Corner L-Back Corner
Other_____

How fast was your vehicle moving upon impact?_____MPH _____Stopped

How fast was the other vehicle(s) moving upon impact?_____MPH_____Stopped

Your position in the car was? Driver Passenger

Were the brakes applied at the time of impact? Yes No Unknown

Did the seat break at the time of impact? Yes No Unknown

Were your seatbelts on at the time of impact? Yes No Unknown

Did the airbags deploy at the time of impact? Yes No Unknown

Where did you go after the accident? Work Home Hospital Urgent Care Family Doctor

If you sought medical care, where did you go?_____

If you sought medical care, how did you get there? Self Friend Ambulance Helicopter

Did you lose Consciousness at the time of the accident? Yes No

Description of accident:_____

_____

Location of Accident:_____

_____

Do you have an attorney? Yes No (if yes, who?)_____

Patient Signature:_____