Auto Accident Info:

t was your position in the vehicle?

☐Driver ☐Front Passenger ☐Rear Passenger ☐Pedestrian (not in car)

▶*What type of vehicle were you driving?*

☐Compact Car ☐Mid Size Car ☐Full Size Car ☐Compact Truck
☐Full Truck ☐Mini Van ☐Full Size Van ☐Small Sport Utility
☐Lg. Sport Util. ☐Motorcycle ☐Motor Home ☐Bicycle

▶*What was your vehicle doing just prior to the accident?*

☐Stopped at a stop light ☐Slowing down to a stop
☐At a complete stop ☐Increasing speed
☐Merging into traffic ☐Changing lanes

Traveling at an approximate speed of:

☐5 mph ☐10 mph ☐15 mph ☐20 mph ☐25 mph ☐30 mph
☐35 mph ☐40 mph ☐45 mph ☐50 mph ☐55 mph ☐60 mph
☐65 mph ☐70 mph ☐75 mph ☐80 mph ☐Faster than 80 mph

▶*Who hit who?*

☐You were struck by another car ☐You struck another vehicle
☐You struck a stationary object

▶*What was your vehicles point of impact?*

☐Front ☐Rear ☐Right Side ☐Left Side
☐Right Front ☐Left Front ☐Right Rear ☐Left Rear

▶*What was the other vehicle doing just prior to the accident?*

☐Stopped at a stop light ☐Slowing down to a stop
☐At a complete stop ☐Increasing speed
☐Merging into traffic ☐Changing lanes

Traveling at an approximate speed of:

☐5 mph ☐10 mph ☐15 mph ☐20 mph ☐25 mph ☐30 mph
☐35 mph ☐40 mph ☐45 mph ☐50 mph ☐55 mph ☐60 mph
☐65 mph ☐70 mph ☐75 mph ☐80 mph ☐Faster than 80 mph

▶*What was the other vehicles point of impact?*

☐Front ☐Rear ☐Right Side ☐Left Side
☐Right Front ☐Left Front ☐Right Rear ☐Left Rear

▶*Were you wearing seat restraints?*

☐Full lap and shoulder restraint ☐Lap restraint only
☐Shoulder restraint only ☐I was not wearing a restraint

▶*What position were your vehicles head rests in?*

☐Lowest position ☐Middle position
☐Highest position ☐No head rest in vehicle

▶*Did your vehicles air bags deploy?*

☐Yes ☐No

▶*Were you prepared for the impact?*

☐Came as complete surprise ☐Aware and braced for collision
☐Aware but not braced for collision

▶*What position was your head and neck in prior to the impact?*

☐Straight forward ☐Tilted forward ☐Rotated to the left
☐Rotated to the right ☐Turned around ☐Toward rear view mirror

▶*What happened to your body at the moment of impact?*

☐Body was tensed for impact ☐Body whipped forward/backward
☐Body torqued and twisted ☐Body was thrown over seat
☐Body was thrown from vehicle ☐Body was pinned in vehicle
☐Body was thrown from side to side ☐Body was cut and bruised

▶*What was your mental/emotional state immediately following?*

☐Unconscious ☐Shaken up
☐Disoriented ☐Shaken up & Disoriented

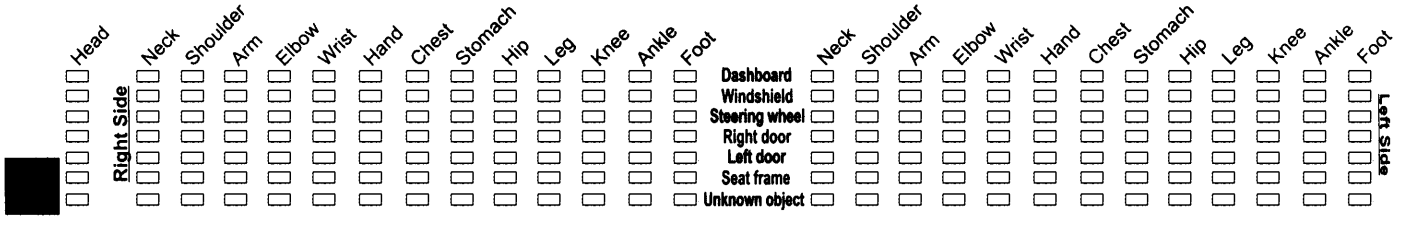
▶*Did you receive medical attention at the scene of the accident?*

☐Yes ☐No

▶*Where did you go immediately following the accident?*

☐Hospital ☐Personal Doctor ☐This Office
☐Home ☐Resumed daily activities

▶*Mark all areas of your body that struck the below listed parts of your vehicle:*



Work Comp Injury

If your injury involved LIFTING, complete this section:

▶*From where were you lifting an object?*

☐Ground level ☐A surface below ground level
☐A surface 1 to 3 feet high ☐A surface 3 to 5 feet high
☐A surface above 5 feet high

▶*How many pounds was the object you were lifting?*

☐1 to 5 pounds ☐5 to 10 pounds ☐10 to 20 pounds
☐20 to 40 pounds ☐40 to 60 pounds ☐Over 60 pounds

▶*What position were you in while lifting the object?*

☐Back was upright and straight ☐Bent over at the waist
☐Twisted to the left side ☐Twisted to the right side

▶*What type of pain did you feel immediately after the injury?*

☐Gripping pain ☐Sharp pain ☐Dull pain
☐Aches ☐Popping feeling ☐Paralysis

If your injury involved FALLING, complete this section:

▶*From where did you fall at work?*

☐Onto the ground while walking ☐Onto the ground while running
☐From 1 to 3 feet high ☐From 3 to 5 feet high
☐From 5 to 8 feet high ☐From higher than 8 feet

▶*What part of your body did you land on?*

☐Head ☐Neck ☐Right Shoulder ☐Left Shoulder
☐Right Arm ☐Left Arm ☐Right Hand ☐Left Hand
☐Back ☐Right Buttock ☐Left Buttock ☐Tail Bone
☐Right Hip ☐Left Hip ☐Right Leg ☐Left Leg
☐Right Knee ☐Left Knee ☐Right Foot ☐Left Foot

▶*What other areas of your body were affected by your fall?*

☐Head ☐Neck ☐Right Shoulder ☐Left Shoulder
☐Right Arm ☐Left Arm ☐Right Hand ☐Left Hand
☐Back ☐Right Buttock ☐Left Buttock ☐Tail Bone
☐Right Hip ☐Left Hip ☐Right Leg ☐Left Leg
☐Right Knee ☐Left Knee ☐Right Foot ☐Left Foot

Other work related injuries:

☐Raised up from bending over ☐Twisted at the waist
☐Wrist injury from repetitive use ☐Wrist injury from pulling

(Please describe ALL injuries in your own words on page 1 of this form)

Job analysis information:

▶*What regular activities did you perform at work?*

☐Sitting ☐Standing ☐Walking
☐Running ☐Driving ☐Lifting
☐Bending/Stooping ☐Squatting ☐Crawling
☐Climbing ☐Crouching ☐Reach above shoulders
☐Kneeling ☐Pushing/Pulling ☐Maintain awkward position

▶*How much do you regularly lift at your job?*

☐Little to none ☐1 to 10 Lbs ☐10 to 20 Lbs ☐20 to 40 Lbs
☐40 to 60 Lbs ☐60 to 80 Lbs ☐80 to 100 Lbs ☐Over 100 Lbs

▶*Do you regularly bend over while lifting?* ☐Yes ☐No

▶*Are your hands subject to any of the below repetitive movements?*

☐Light grasping (left hand) ☐Light grasping (right hand) ☐Light grasping both
☐Firm grasping (left hand) ☐Firm grasping (right hand) ☐Firm grasping both
☐Typing ☐Using a computer mouse

▶*How many hours do you regularly perform the below activities?*

Sitting: ☐1-2 hours ☐2-4 hours ☐4-6 hours ☐6-8 hours
Standing: ☐1-2 hours ☐2-4 hours ☐4-6 hours ☐6-8 hours
Walking: ☐1-2 hours ☐2-4 hours ☐4-6 hours ☐6-8 hours
Lifting: ☐1-2 hours ☐2-4 hours ☐4-6 hours ☐6-8 hours