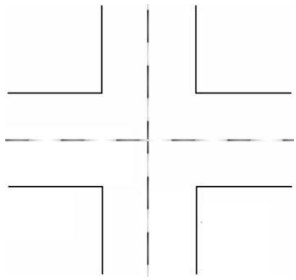


## Motor Vehicle Injury Form

Name	Date of accident:
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Notes:

<p>Wearing seat belt? <input type="radio"/> No <input type="radio"/> Yes</p> <p>Airbag deployed? <input type="radio"/> No <input type="radio"/> Yes</p>	<p>Position: <input type="radio"/> driver <input type="radio"/> front passenger <input type="radio"/> rear seat</p> <p>Direction: <input type="radio"/> rear end <input type="radio"/> front end <input type="radio"/> side impact <input type="radio"/> spin <input type="radio"/> flip</p>
<p>Head turned? <input type="radio"/> No <input type="radio"/> Yes: <input type="radio"/> L <input type="radio"/> R</p> <p>Hands on wheel? <input type="radio"/> No <input type="radio"/> Yes: <input type="radio"/> L <input type="radio"/> R</p>	<p>Did your body hit anything? <input type="radio"/> No <input type="radio"/> Yes, Explain:</p>
<p>Loss of consciousness? <input type="radio"/> No <input type="radio"/> Yes</p> <p>Treated by EMS? <input type="radio"/> No <input type="radio"/> Yes</p> <p>Visit Urgent Care/ER? <input type="radio"/> No <input type="radio"/> Yes, Where?</p>	<p>Describe how accident happened:</p> <div style="text-align: center;">  </div>
<p>Describe treatment given (meds/x-ray/CT):</p>	<p>Any lacerations/bleeding? <input type="radio"/> No <input type="radio"/> Yes, Describe:</p>
<p>Missed work? <input type="radio"/> No <input type="radio"/> Yes, How Long?</p>	<p>Activity limitations? <input type="radio"/> No <input type="radio"/> Yes, Explain:</p>

Patient signature	Today's date
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Initial \_\_\_\_\_