Arizona Injury Medical Associates, P.L.L.C.
Physiatry Care

Motor Vehicle Collision History

Name:_____ Date of Collision:_____

You were: Driver ☐ Front Passenger ☐ Rear Passenger on: left ☐ right ☐ center ☐

Your vehicle:_____ Other vehicle:_____
Year Make Model Year Make Model

Seat type: bucket ☐ bench ☐ Seat had: headrest ☐ high-back ☐ neither ☐

Top of headrest (or seat back if none) was: above ☐ at ☐ below ☐ the center of your ear.

Distance between back of your head and headrest was _____ inches. Don't know ☐.

Vehicle had: driver airbag ☐ passenger airbag ☐ side airbag ☐ Did they deploy? Yes ☐ No ☐

You were wearing: shoulder and lap belt ☐ shoulder belt ☐ lap belt ☐ no seatbelt ☐

Your vehicle: hit another ☐ was hit ☐ on street ☐ highway ☐ freeway ☐ other _____

Road surface was dry ☐ wet ☐ icy ☐ snow covered ☐

Approximate speed of your vehicle at time of impact:_____ Other vehicle:_____

Damage to your vehicle was to: front ☐ right side ☐ left side ☐ rear ☐ $ of damage to vehicle: $_____

Was there damage to the vehicle's interior? yes ☐ no ☐ If yes, what was damaged?

_____

Did you see the collision coming? yes ☐ no ☐ If yes, what did you do?

_____

Your body position at impact, including head-neck, hands, and feet:_____

_____

When the collision occurred, what happened to your body?_____

_____

Did you lose consciousness? yes ☐ no ☐ If yes, for about how long?_____

What immediate symptoms did you have?_____

_____

You left the accident scene in: same vehicle ☐ ambulance ☐ other vehicle ☐

Did you have more symptoms later? yes ☐ no ☐ If so, what and when did they start?_____

_____

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