

Motor Vehicle Accident Report

Name: (Label).....

Date of report.....

Date of MVA:.....Time of MVA:.....

Location of MVA:.....

I was in the (check one): Driver's seat....Front passenger seat....Rear seat behind driver....
Rear seat behind front passenger seat.... Rear Centre seat....

I was....was not.... wearing a full seat belt (check which applies).

The seat head rest was properly adjusted to support the back of my head: Yes.... No....

My* vehicle was a: Make.....Model.....Year.....

My* vehicle was struck by a: Make.....Model.....Year.....

Section 1: Description of collision:

At the moment of impact 'my*' vehicle was (check which applies): In motion... Fully stopped...

1. Another vehicle was involved: Yes... No...
2. My* vehicle hit the other vehicle: Yes... No...
3. The other vehicle hit my* vehicle: Yes... No...
4. There was more than one impact to my vehicle: Yes... No...
5. The impact also involved a non-vehicular structure, (e.g .tree, concrete barrier &c): Describe:.....

.....

6. The impact occurred directly to the **Rear** of my* vehicle: Yes... No...
7. The impact occurred directly to the **Front** of my* vehicle: Yes... No...
8. The impact occurred directly to the driver's **side** of my* vehicle: Yes... No...
9. The impact occurred directly to the passenger's **side** of my vehicle: Yes... No...
10. There was more than one impact to different parts of my* vehicle: Describe:.....

.....

As a result of the impact 'my*' vehicle was pushed forward a distance ofFeet/Metres.

As a result of the impact my* vehicle was pushed sideways a distance ofFeet/Metres.

As a result of the impact my* vehicle was sent into a spin **Yes... No... Direction**

* The term 'my' does not imply ownership of the vehicle, but merely identifies vehicle in which you were travelling.

Motor Vehicle Accident Report Continued: Name:.....Date of report:

There was/is visible damage to my* vehicle: **Yes... No... Describe**.....

.....

There was/is visible damage to the other vehicle: **Yes... No... Describe**.....

.....

The estimated value of damage to my vehicle is: \$.....

Section 2: How the collision affected you.

Please read all the questions carefully before you answer them. Note that they are divided into two main groups, physical effects and psychologic or emotional effects. Please also pay careful attention to the *timing* of the effects; e.g. things you may have felt within seconds of the impact, versus things that may not have appeared until hours later. Make sure you answer only what is being asked. There will be opportunity later for you to provide additional information not covered here.

1. After the impact I got out of the car immediately. Yes.... No....
2. After the impact I remained sitting in my seat for some time (estimate duration):.....
3. I was assisted to get out of the car by another person: Yes... No... Describe.....
4. Immediately (first 30 to 60 seconds) after the impact I felt pain or discomfort in the following areas:
.....
.....
5. Within 10 to 30 minutes of the impact I became aware of *new* pain or discomfort in the following areas:.....
.....
.....
6. Within 6 hours of the impact I became aware of *new* pain or discomfort in the following areas:.....
.....
.....
7. Within 48 hours of the impact I became aware of *new* pain in the following areas.....
.....

Motor Vehicle Accident Report Continued: Name:.....Date of report:

8. Immediately (first 30 to 60 seconds) after the impact my emotional state included (underline the emotions that you felt, then write a more detailed description on the next page of how these feelings affected you as well as any other emotions or feelings that were troubling you):

No feelings at all Surprise Shock Frustration Anger Fear

Tearfulness Resignation Concern Compassion Confusion Anxiety

(Describe emotional responses)

.....
.....
.....
.....

9. Since the, the following describes my emotional response to the accident (*check all that apply*):

My emotional state is the same as it was before the accident.

I am happier and more relaxed than before the accident.

I am more tense and irritable.

I can't stop thinking about the accident.

I have recurring dreams about the accident.

My ability to drive or be a passenger in a vehicle hasn't changed.

I have become a 'nervous' passenger in a vehicle.

I have become a nervous driver.

I drive as much as usual.

I avoid driving if I can.

I avoid driving past the place where I was involved in that accident.

I wish people would just not talk about the accident.

Loud noises and tire screeching startle me much more than before.

My sleep has not changed.

My sleep has changed.

I enjoy everyday pleasures just as much as always.

I seem to have lost interest in the things I liked to do.

My relationships with people haven't changed at all.

I don't seem to want to be close to some people they way I was before the accident.

Please use the following space to add any additional information you think may be helpful:.....

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Signed:.....

