AUTOMOBILE ACCIDENT INFORMATION

Name: _____ Today's date: _____

Date of accident: _____ Time of accident _____AM/PM Location of accident_____

Describe how accident happened in detail:

_____

_____

_____

In the accident were you the ☐ Driver ☐ Front Passenger ☐ Rear Passenger Left / Center / Right

☐ Pedestrian ☐ Other

Were you using a seatbelt? ☐ Yes ☐ No

If yes, was it a: ☐ Lap seatbelt ☐ Shoulder-lap seatbelt

Did you have a head restraint? ☐ Yes ☐ No

In relation to the base of your skull, where was the headrest? ☐ Above ☐ Below ☐ At base of skull

Did your car strike the other? ☐ Yes ☐ No

Did the other car strike your car? ☐ Yes ☐ No

Were you struck from ☐ Behind ☐ Front ☐ Left side ☐ Right side

Was your car heading ☐ North ☐ South ☐ East ☐ West

Road conditions: ☐ Wet ☐ Dry ☐ Icy ☐ Other

Describe, in detail your symptoms immediately following the accident:

_____

_____

_____

Did air bag deploy? ☐ Yes ☐ No Did you receive any injuries or bruising from the seatbelt or air bag? ☐ Yes ☐ No

Did your body hit anything in the car? ☐ No ☐ Yes Describe?_____

Did you lose consciousness? ☐ Yes ☐ No How long? _____

What was the position of your head at the time of the impact? ☐ Straight Ahead ☐ Turned Right ☐ Turned Left

Did you see the collision coming? ☐ Yes ☐ No Was there a second collision? ☐ Yes ☐ No With what? _____

Was <u>your</u> car moving at the time of impact? ☐ Yes ☐ No If yes, was it ☐ Slowing ☐ Gaining Speed ☐ Steady Speed

Was the <u>other</u> car moving at the time of the impact? ☐ Yes ☐ No

If yes, was it: ☐ Slowing ☐ Gaining Speed ☐ Steady Speed

Estimated speed of your vehicle _____ Estimated speed of the other vehicle _____

Did the police come to the scene of the accident? ☐ Yes ☐ No Was there a report? ☐ Yes ☐ No

Were traffic citations issued to: ☐ You ☐ Driver of Your Car ☐ Driver of the Other Car ☐ No Citations Given

Did the paramedics come to the scene? ☐ Yes ☐ No Treated at scene? _____ Transported? _____

Did you go to the hospital? □ Yes □ No If yes, Name of Hospital / E.R.: _____

Attending Doctor: _____ Treatment Given? _____

□ X-rays □ Urinalysis □ Blood tests □ Medication □ Other _____

Other Doctors seen for this injury? _____ Length of Care: _____

Have you lost time from work? □ Yes □ No Dates: From _____ thru _____

Are your work duties restricted due to this accident: □ Yes □ No Is there light duty work you can request? □ Yes □ No

Please indicate your daily job duties and activities you are occasionally asked to perform:

□ Standing □ Driving □ Operating Equipment □ Sitting □ Twisting □ Walking

□ Lifting □ Crawling □ Work with arms above head □ Bending □ Typing □ Stooping

Check symptoms you have noticed since the accident:

□ Headache	□ Cold Sweats	□ Digestive Trouble	□ Loss of Smell
□ Dizziness	□ Arm/Shoulder Pain	□ Shortness of Breath	□ Loss of Taste
□ Neck Pain/Stiff	□ Eyes Sensitive to Light	□ Depression	□ Fatigue
□ Vomiting	□ Head Feels to Heavy	□ Leg Pain	□ Broken Bones
□ Fainting	□ Pins & Needles in Arms	□ Memory Loss	□ Cold Feet
□ Jaw Problems	□ Difficulty Sleeping	□ Ears Ringing	□ Cold Hands
□ Nervousness	□ Pins & Needles in Legs	□ Loss of Balance	□ Low Back Pain
□ Irritability	□ Numbness _____	□ Upper Back Pain	□ Tension
□ Bruises	□ Chest Pain	□ Blurred Vision	□ Nauseated
□ Light Headed	□ Disoriented	□ Pain Behind Eyes	□ Mid Back Pain

Since this injury, are your symptoms: □ Improving □ Worsening □ Same

********** Insurance Information: **********

Do you have:	**Health Insurance?** □ Yes □ No	**Automobile Insurance?** □ Yes □ No
Your relation to insured:	□ Self □ Spouse □ Child □ Other	□ Self □ Spouse □ Child □ Other
Insured's Name:		
Insured's Date of Birth:		
Insured's ID #:		
Insurance Company:		
Address:		
Phone & Adjuster name:		
Policy # / Claim #:		
Contacted Insurance?	□ Yes □ No	□ Yes □ No **Med-Pay?** □ Yes □ No

	Vehicle in which you were a Passenger	**Other Vehicle Involved**
Driver's Name:		
Insured's Name:		
Insured's Address:		
Insurance Company:		
Insurance Address:		
Phone & Adjuster name:		
Policy # / Claim #:		
Contacted by Insurance Co.	□ Yes □ No	□ Yes □ No

Have you retained an Attorney? □ Yes □ No	Date Retained:
Attorney's Name:	Firm Name:
Address:	Phone: