

AUTOMOBILE ACCIDENT HISTORY

Name: _____ Address: _____

Sex: ____ Age: ____ Driver's License #: _____

Claim Number: _____ Attorney: _____

Insurance Name: _____ Phone #: _____

Address _____

General Symptoms:

Did you hit any part of your body during the collision (head or chest on steering wheel or dash board)? ____ If Yes, which part and how? _____

Did you become/have: **Confused Disoriented Light-Headed Dizzy**
Nauseous Blurred Vision Ringing in the ears

Do you still have any symptoms? ____ Which ones? _____

Are you currently suffering from any of the following?

Restlessness Irritability Poor Concentration Memory Loss Insomnia

Did you go to a hospital? ____ If Yes, which hospital? _____

How did you get to the hospital? _____

What parts of your body were x-rayed at the hospital? _____

What did the hospital do for your injuries? _____

Were you bleeding at the time of the accident? _____

What bruises did you sustain during this accident? _____

Did you receive care from any other medical professional? ____ Name? _____

What type of care were you given and for how long? _____

Where did you feel the pain? _____

What are your current symptoms? _____

Have you ever been injured in a similar manner? ____ If Yes, how and when? _____

Accident History:

Date: _____ Time: _____

State how the accident happened in your own words: _____

Were you Driving? **Yes No** Were you a passenger in the: **Front or Back**

Were you on the: **Right Side or Left Side**

Were you looking straight ahead? **Yes No** If No, then where were you looking? _____

Was it your car? **Yes No** If Not, Who's? _____

Other People in car: Name and Address:

- 1) _____ Address _____
- 2) _____ Address _____
- 3) _____ Address _____

Was your car stopped at the time of impact? **Yes No**

If Yes, was the driver's foot also on the brake? **Yes No**

If No, then estimate the speed of the vehicle you were in: _____ mph

If your vehicle was moving at the time of impact, was it:
slowing down? **Yes No** Accelerating? **Yes No**
traveling at a steady rate of speed? **Yes No**

Were you wearing a seat belt? **Yes No** Was the shoulder harness on? **Yes No**

Did you receive any injury or bruise from the seat belt? **Yes No**

If yes, then describe the injury: _____

How far is the top of the headrest or seatback from the top of your head: _____ inches
above or below

Was it: **Daylight Night Dusk Dawn**

Were you tired? **Yes No** Were you awake? **Yes No**

How long had you been in the car? _____

Where were you prior to the accident? _____

What were the weather conditions? _____

What was the posted speed limit? _____ mph How fast were you going? _____ mph

Type of road? **Two Lane Four Lane Gravel Tar**

Did the collision occur at a **stop sign**? _____ a **traffic light**? _____ an **intersection**? _____

Which area of your car was damaged? **Front Back Left Side Right Side**

What damage was done to your car?

Inside: _____

Outside: _____

Other: _____

Was the other vehicle moving during the collision? _____ Approximate speed? _____ mph

If the other vehicle was moving at the time of the collision, was it:

Slowing Down Accelerating Traveling at a steady speed

What was the damage to the other car? **Yes No**

Inside: _____

Outside: _____

What type of vehicle were you driving? Make: _____ Model: _____ Year: _____

What condition was your car in prior to the accident? _____

Do you have pictures of the involved automobile? **Yes No**

What is the estimated cost damage to the vehicle you were in? \$ _____

Which of the following parts of your vehicle were damaged during the accident?

Windshield Right/Left Side Window Steering Wheel

Other _____

What other type of vehicle was involved in the accident? **Car Truck Motorcycle**

Size and type: _____

Was a police report filed? **Yes No** By Police of: **City County State**

Who was ticketed? _____

For what? _____

Did your vehicle strike anything else? **Yes No**

If Yes, what? **Another Car a Sign a Tree a Bridge Other** _____

Did you lose consciousness (black out) on impact? **Yes No** How long: _____

Did you experience a flash of light or explosion in your head? **Yes No**

Do you remember the impact? **Yes No**

Were you aware of the approaching collision prior to impact? **Yes No**

Did your vehicle go off the road? **Yes No**

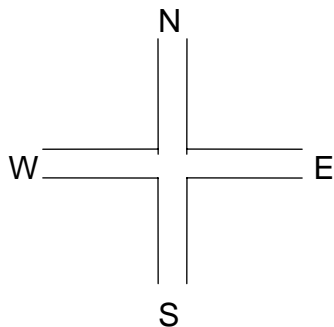
If so: **Into an Embankment a Ditch** How Deep? _____

Does it bother you to ride in a car now? **Yes No** If so, as a: **Driver Passenger**

Have you had any time loss from work? **Yes No**

Have you had any outside help? **Yes No**

Please Draw the Accident:



Patient Signature _____ Date _____