

Automobile Accident History Form

Your Name: _____ Today's Date: _____

Date of Accident: _____ Time of Accident: _____ am/pm

Road conditions at the time of accident: WET DRY ICY OTHER

Did the police come to the accident scene? YES NO

Is there a report? YES NO Did you request the report? YES NO

Did you go to the hospital? YES NO _____

If yes, what 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? _____

How long did you stay at the hospital? _____

What bleeding cuts did you sustain during this accident? _____

What bruises did you sustain during this accident? _____

Where were you seated in the vehicle?

DRIVER FRONT PASSENGER LEFT REAR MIDDLE REAR RIGHT REAR

Were you aware of the approaching collision prior to impact, or did impact catch you by surprise?

AWARE SURPRISED

Did you lose consciousness (black out) upon impact? YES NO; How long:

Did you experience a flash of light or explosion in your head? YES NO

Did you become one of the following from the accident?

CONFUSED DISORIENTED LIGHTHEADED DIZZY

NAUSEATED BLURRED VISION RING/BUZZ IN EARS

If you still have any of those symptoms, which ones? _____

Are you currently suffering from any of the following:

DIFFICULT CONCENTRATING RESTLESSNESS SLEEPLESSNESS

REDUCED TOLERANCE TO HEAT DIFFICULTY WITH MEMORY CHILLS

REDUCED TOLERANCE TO ALCOHOL IRRITABLE FORGETFULNESS

How far is the top of the headrest or seat back from the top of your head (approximately):

_____ inches above or below

Were you wearing a seat belt? YES NO

If yes, was it a LAP SEATBELT or a SHOULDER-LAP SEATBELT

List the year, make and model of the the vehicle you were in:

Year _____ Make _____ Model _____

Was you 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

Gaining Speed? YES NO

Traveling at a steady rate of speed? YES NO

On what part of the automobile did your following body parts hit?

Head Hit _____	chest hit _____
right/left shoulder hit _____	right/left arm hit _____
right/left hip hit _____	right/left leg hit _____
right/left knee hit _____	other _____

Did you receive any injury or bruise from the seat belt? YES NO

If YES then describe: _____

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

Which of the following car parts broke during the accident?

WINDSHIELD	FRONT SEAT BACK	RIGHT/LEFT SIDE WINDOW
STEERING WHEEL	OTHER	

Was the trunk of your body pointed straight forward at the time of the collision? YES NO

If no, how was it turned? _____

Was you head pointed straight forward? YES NO

If no, what direction was it turned and by how much? _____

What is the year, make and model of the the other vehicle?

Year _____ Make _____ Model _____

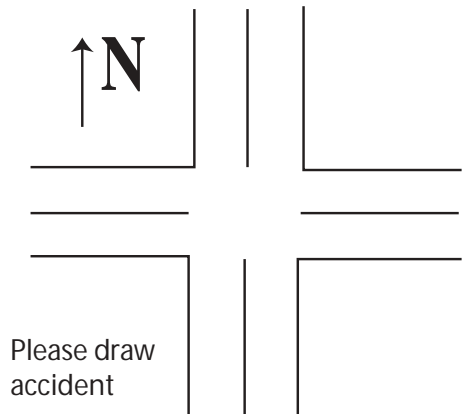
Was the other vehicle moving at the time of the collision? YES NO

If yes, what was its approximate speed? _____ mph

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

SLOWING DOWN GAINING SPEED TRAVELING AT A STEADY SPEED

Please describe, to the best of your knowledge, what happened during this accident:



Thank you for taking the time to fill out this form.