AUTO ACCIDENT HISTORY FORM

NAME: _____ TODAY'S DATE:_____

ADDRESS:_____

Date of Birth_____ (Circle One) Home or Cell #:_____

DATE OF ACCIDENT:_____AUTO INSURANCE CO.:_____

INS CO. PHONE NUMBER _____ NAME OF ADJUSTOR_____

MEDICAL CLAIM #:_____Insurance Address:_____

LOCATION OF ACCIDENT:_____

TIME OF ACCIDENT:_____PLEASE DESCRIBE THE ACCIDENT:_____
_____
_____
_____

WERE YOU THE ___DRIVER ___PASSENGER ___PEDESTRIAN?
WERE YOU STRUCK FROM ___BEHIND ___LEFT SIDE ___RIGHT SIDE ___ OR WERE YOU PARKED?

DID YOUR CAR STRIKE THE OTHER(S) INVOLVED? ___YES ___NO

OR DID THE OTHER CAR STRIKE YOURS? ___YES ___NO

AS A RESULT OF THE ACCIDENT, WERE TRAFFIC CITATIONS ISSUED TO YOU? ___YES ___NO

TO THE DRIVER OF THE OTHER CAR? ___YES ___NO

TO THE DRIVER OF YOUR CAR? ___YES ___NO

LIST THE EXTENT OF INJURIES AS YOU KNOW THEM:_____

_____

DID YOU REQUIRE POST-ACCIDENT HOSPITALIZATION? ___YES ___NO

CHECK THE SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

__HEADACHE	__DIZZINESS	__DEPRESSION	__FATIGUE
__STOMACH UPSET	__LIGHT BOTHERS EYES	__BUZZING IN EARS	__DIARRHEA
__NECK PAIN	__HEAD SEEMS TOO HEAVY	__LOSS OF MEMORY	__FEET COLD
__NECK STIFF	__PINS & NEEDLES IN ARMS	__EARS RING	__HANDS COLD
__FAINTING	__SLEEPING PROBLEMS	__LOSS OF BALANCE	__BACK PAIN
__FACE FLUSHED	__PINS & NEEDLES IN LEGS	__CONSTIPATION	__TENSION
__NERVOUSNESS	__NUMBNESS IN FINGERS	__LOSS OF SMELL	__FEVER
__IRRITABILITY	__NUMBNESS IN TOES	__LOSS OF TASTE	__CHEST PAIN
__COLD SWEATS	__SHORTNESS OF BREATH	__OTHER	

NAME:_____**DATE:**_____

HAVE YOU LOST ANY DAYS WORK?_____ DATES:_____

HAVE YOU BEEN CONTACTED BY AN INSURANCE ADJUSTER OR COMPANY REPRESENTATIVE REGARDING THIS CLAIM? ___YES ___NO

DO YOU HAVE AN ATTORNEY ADVISING YOU IN THIS CASE? ___YES ___NO

SEAT BELTS ON?_____SHOULDER HARNESS ON?_____

WAS IT: _____DAYLIGHT? _____NIGHT?_____DUSK?_____DAWN?_____

WERE YOU TIRED?_____WERE YOU AWAKE?_____

HOW LONG HAD YOU BEEN IN THE CAR?_____

WHERE WERE YOU PRIOR TO THE ACCIDENT?_____

WHAT WERE THE WEATHER CONDITIONS?_____

WHAT WERE THE TRAFFIC CONDITIONS?_____

WHAT WAS THE POSTED SPEED LIMIT?_____HOW FAST WERE YOU GOING?_____

TYPE OF ROAD: TWO LANE_____FOUR LANE_____GRAVEL_____ TAR_____

DID IT HAPPEN AT A STOP SIGN?_____DID IT HAPPEN AT A TRAFFIC LIGHT?_____

DID IT HAPPEN AT AN INTERSECTION?_____

WAS YOUR CAR HIT _____FRONT _____BACK _____ LEFT SIDE _____RIGHT SIDE

WHAT DAMAGE WAS DONE TO YOUR CAR?

INSIDE:_____

OUTSIDE:_____

OTHER:_____

_____

IF YOU STRUCK ANOTHER CAR, DID YOU STRIKE THE _____FRONT _____BACK _____SIDE

DID YOUR VEHICLE STRIKE ANYTHING ELSE?_____

WHAT WAS THE DAMAGE TO THE OTHER CAR?

INSIDE:_____

OUTSIDE:_____

WHAT TYPE OF VEHICLE WERE YOU DRIVING? MAKE_____YEAR_____

WHAT CONDITION WAS YOUR VEHICLE IN <u>PRIOR</u> TO THE ACCIDENT? _____

WERE YOU COMPLETELY CONSCIOUS AFTER THE ACCIDENT?_____

DO YOU REMEMBER THE IMPACT?_____

NAME:_____**DATE:**_____

DID YOUR VEHICLE GO OFF THE ROAD?_____**WHERE?**_____

DOES IT BOTHER YOU TO RIDE IN A CAR NOW?_____

STATE ANY STRANGE EVENTS THAT HAPPENED DURING OR IMMEDIATELY FOLLOWING THE ACCIDENT:_____

_____

_____

HAVE YOU LOST ANY TIME FROM WORK?_____

HAVE YOU HAD TO HAVE OUTSIDE HELP? EXPLAIN. _____

_____

_____

_____

_____

PLEASE DRAW THE ACCIDENT?

N

W----------E

S