

Name: _____ Date: _____

Date of accident time of accident: _____

City of accident street of accident: _____

Did police come to the scene? **Yes No**

Is there a police report? **Yes No**

Did you go to the hospital? **Yes No**

If yes...what is name of hospital: _____

Any x-rays, scans, MRI's or other tests? _____

How did they treat you? _____

How long did you stay? _____

What bruises, cuts, scrapes did you receive? _____

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

Did you lose consciousness (black out) after impact? **Yes No**

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

Did you suffer any of the following symptoms from the accident?

Confused disoriented light headed dizzy Nauseated Blurred vision

Ringling/ buzzing ears Changes in bowel or bladder function

Do you still have any of these symptoms? _____

Are you currently suffering from any of the following?

Restlessness Irritable Sleeplessness Forgetfulness

Difficult Concentrating Difficult with Memory

Reduced Tolerance to Heat Reduced Tolerance to Alcohol

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

_____ inches **above** or **below**.

Were you wearing a seatbelt: **Yes No**

If yes, was it a lap seatbelt or a shoulder-lap seatbelt? _____

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

Year: _____ Make: _____ Model: _____

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**

Gaining down? **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 _____ Right/left arm _____

Right/left hip _____ Right/left leg _____

Right/left knee _____ Other _____

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

If yes, please describe: _____

Was your body pointed straight forward at the time of impact? **Yes** **No**

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

What is the year, make and model of the **other** car?

Year: _____ Make: _____ Model: _____

Was the other vehicle 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:

Driver of other Vehicle's Name: _____

Insurance Co: _____ Policy #: _____

Local Agent: _____ Phone #: _____

Did they receive a ticket? **Yes** **No**

Did you receive a ticket? **Yes** **No**