

AUTOMOBILE ACCIDENT HISTORY FORM

Today's Date _____

Your Name _____

Date Of Accident _____ Time Of Accident _____ am/pm

City Of Accident _____ Street Of Accident _____

Road Conditions At The Time Of Accident: **Wet Dry Ice Other** _____

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

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

If yes, what is the name and city of the 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? _____

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

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 experience any of these due to the accident? (Please circle) **Confused; Disoriented; Light Headed; 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 (please circle)? **Restlessness; Irritable; Difficult Concentrating; Difficult with Memory; Sleeplessness; Forgetfulness; 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 _____ shoulder-lap seatbelt? (check one)

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

Year _____ **Make** _____ **Model** _____

Was the 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 speed? **Yes** **No**

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

Head hit _____ **Chest hit** _____

Rt/Lt Shoulder hit _____ **Rt/Lt arm hit** _____

Rt/Lt Hip hit _____ **Rt/Lt Leg hit** _____

Rt/Lt Knee hit _____ **Other:** _____

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

If yes, then describe: _____

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

Which of the following vehicle parts broke during the accident? (please circle)

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 your head pointed straightforward? **Yes** **No**

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

List the year, make and model of 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 collision, was it (please circle):

Slowing Down **Gaining Speed** **Traveling at a Steady Speed**

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

Are you currently working? Yes No: Off work on: _____

Returned to work on: _____