ACCIDENT/INJURY FORM

NAME____ DATE_____________________

Date of Accident__________ Time: ___am ___pm Location of Accident______________

Were You: ( ) Driver ( ) Passenger ( ) Pedestrian

Were there any other passengers in your vehicle at the time of accident? Y / N

Make/model of your vehicle? Make/model of other vehicle?

Were you struck from: ( ) Behind ( ) Right Side ( ) Left Side ( ) Front ( ) Parked

Did your car strike the others involved: ( ) Yes ( ) No ( ) Undetermined

Did the other car strike yours: ( ) Yes ( ) No ( ) Undetermined

The driving conditions were: ( ) Clean & Dry ( ) Wet ( ) Icy ( ) Foggy ( ) Dark

Did you see the accident about to occur? ( ) Yes ( ) No Were you able to brace yourself? Y / N

As a result of the accident, were traffic citations issued to you? ( ) Yes ( ) No

Were you wearing your seatbelt at the time of accident? Y/N Did the seat belt engage? Y / N

How fast was your vehicle moving at the time of impact ____ mph Other vehicle ____ mph

Where was the headrest positioned? Above / Below / Level With the head?

Did the airbags deploy? Y/N Front? Y/N Side? Y/N Rear? Y/N

Which direction were you facing at the point of impact? Left / Right / Straight Ahead / Looking Down

Did your body strike any part of the interior? ( ) Yes ( ) No If yes, what did you strike? __________

Was there damage to either vehicle? Y / N Yours $ ______ Theirs $ ______

Was your vehicle drivable following the accident? Y / N

Were you evaluated at the scene of the accident? Y / N Transported? Y / N If Yes, Where?

Where did you go following the accident? How did you arrive there? Drove Self / Other

Have you received treatment from any other healthcare provider for current symptoms? Y / N

CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT

( ) Headache
( ) Neck Pain
( ) Neck Stiff
( ) Dizziness
( ) Back Pain
( ) Nervousness
( ) Tension
( ) Irritability
( ) Chest Pain
( ) Sleeping Problems
( ) Head Too Heavy
( ) Pins & Needles in Arms
( ) Pins & Needles in Legs
( ) Numbness in Fingers
( ) Numbness in Toes
( ) Shortness of Breath
( ) Fatigue
( ) Depression
( ) Lights Bother Eyes
( ) Loss of Memory
( ) Ears Ringing
( ) Face Flushed
( ) Buzzing in Ears
( ) Loss of Balance
( ) Fainting
( ) Loss of Smell
( ) Loss of Taste
( ) Diarrhea
( ) Feet Cold
( ) Hands Cold
( ) Stomach Upset
( ) Constipation
( ) Cold Sweats
( ) Fever
( ) Other

Did you require post-accident hospitalization? ( ) Yes ( ) No

Have you lost any days of work? ( ) Yes ( ) No If Yes, _________ through ________

INSURANCE INFORMATION

Your Insurance Company ___________________________

Have you been contacted by an insurance adjustor regarding this claim ( ) Yes ( ) No

If yes, name of adjustor_____________________________ Phone ________________________

Do you have an attorney that has advised you in this case: ( ) Yes ( ) No

If yes, attorney's name______________________________ Law Firm ______________________