

**AUTOMOBILE ACCIDENT HISTORY FORM**

Your Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Date of Accident: \_\_\_\_\_ Time of accident: \_\_\_\_\_ am/pm  
City of Accident: \_\_\_\_\_ Street of Accident: \_\_\_\_\_  
Road conditions at the time of the accident: WET, DRY, ICY, OTHER:  
Did the police come to the accident scene? YES NO Is there a report? YES NO  
Did you go to a 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, 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 from 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, DIFFICULT CONCENTRATING, SLEEPLESSNESS, REDUCED TOLERANCE TO HEAT, IRRITABLE, DIFFICULTY WITH MEMORY, FORGETFULNESS, 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 \_\_\_\_\_ 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

**AUTOMOBILE ACCIDENT HISTORY FORM cont.**

Was 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

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:

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

Which of the following car 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 straight forward? YES NO

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

What is 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

Was the other vehicle was moving at the time of the 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 this accident:

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