

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:

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:
