

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? _____

Where 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
Ringing/ buzzing ears Changes is 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 speed? **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**