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? YES NO; Is 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 the accident?___________________________
What bruises did you sustain during the accident?_______________________________

Where were you seated in the vehicle?____

Were you aware of the approaching collision prior to impact, or did the impact catch you by surprise? AWARE SURPRISE

Did you lose consciousness (black out) upon impact? YES NO; How long:__________
Do you remember the actual collision? YES NO

Did you experience a flash of light or explosion in your head? YES NO

Did you become: CONFUSED DISORIENTED LIGHT HEADED DIZZY NAUSEATED BLURRED VISION RINGING 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

What is the approximate distance between the back of your head and your vehicle's headrest? __________inches

Did your head go back over the top of your vehicle's headrest? YES NO

Were you wearing your seat belt? YES NO
If yes, was it a lap seat belt shoulder-lap seat belt

Does your vehicle have an airbag? YES NO
Did the air bag deploy in this accident? YES NO
Did you receive an injury from the airbag? YES NO
Please describe:____

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

Was your vehicle 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: ___________m.p.h.

On 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 left hit______________
right / left knee hit_____________ other:____________________

Did you receive any injury or bruise from the seat belt (i.e. breast or abdomen)? YES NO
If yes, please describe:____

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

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

windshield front seat
right / left side window other________________________
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:_____________

What was the estimated speed that the other vehicle was traveling? _________m.p.h.