Automobile Accident History Form

Name: ______________________________ Today's Date: ______________

Date and time of Accident: ______________________________

Location (city, street address): ______________________________

Your Auto Insurance Company: ______________________ Claim #: ____________

Phone # of Ins. Co: ____________________ Insured's Name: ____________________

Name of part who hit you: ______________________________

The Other Party's Auto Insurance Company: ______________ Claim #: ____________

Phone # of Ins. Co: ____________________ Insured's Name: ____________________

Road conditions at the time of the accident: ☐ Wet ☐ Dry ☐ Icy Other ____________

Were the police called to the scene of the accident? ☐ Yes ☐ No Is there a police report? ☐ Yes ☐ No

Did you go the hospital? ☐ Yes ☐ No Were you taken to the hospital by ambulance? ☐ Yes ☐ No

What is the name & location of the hospital? ______________________________

What was done for you at the hospital? ______________________________

Did you get cuts? ☐ Yes ☐ No Bruises? ☐ Yes ☐ No Other____________________

Where were you seated in the vehicle? __________ Who else was in the vehicle? __________

Did you receive any injury or bruise from the seatbelt? ☐ Yes ☐ No Air bag? ☐ Yes ☐ No

Were you wearing a seat belt? ☐ Yes ☐ No Did you have a shoulder harness? ☐ Yes ☐ No

The type of accident: ☐ head-on-collision ☐ rear-end-collision ☐ broad-side-collision ☐ non-collision

Were you aware of the impeding accident? ☐ Yes ☐ No Surprised? ☐ Yes ☐ No

Did you lose consciousness? ☐ Yes ☐ No Did you experience "flash of light"? ☐ Yes ☐ No

After the accident, did you experience?

☐ blurred vision
☐ difficulty breathing
☐ disorientation
☐ irritability
☐ ringing or buzzing in ears
☐ reduced tolerance to heat or alcohol
☐ confusion
☐ difficulty concentrating or focusing
☐ dizziness
☐ light-headedness
☐ sleeplessness
☐ undue sensitivity to light or sounds
☐ depression
☐ difficulties with memory
☐ heart palpitations
☐ nausea
☐ forgetfulness
☐ restlessness

Since the accident, did you experience?

☐ headaches
☐ neck pain
☐ ear pain
☐ facial pain/ numbness
☐ jaw pain (TMJ)
☐ hand/ arm pain
☐ upper back pain
☐ shoulder pain
☐ rib pain
☐ chest pain/ tightness
☐ stiffness in joints
☐ low energy
☐ low back pain
☐ hip pain
☐ leg pain
☐ feet pain/ numbness
☐ leg cramps
☐ muscles spasms

Did an airbag deploy? ☐ Yes ☐ No Approximately how far, in inches, is the top of the headrest or seatback from the top of your head? ____________________

What part of the car was struck? ☐ Front ☐ Rear ☐ Right-front ☐ Left-front ☐ Right-rear ☐ Left-rear

The car you were in: year __________, Make __________, and Model __________

The other vehicle: year __________, Make __________, and Model __________

At the time of the impact, your vehicle was: ☐ stopped ☐ moving ☐ slowing down ☐ speeding up

At the time of the impact, the other vehicle was: ☐ stopped ☐ moving ☐ slowing down ☐ speeding up

If the car was stopped, was the driver's foot on the brake? ☐ Yes ☐ No

What direction was the trunk of your body pointed at the time of the impact? __________

What direction was your head pointed at the time of the impact? __________

Which part of the automobile did the following parts of your body hit?

Head __________ Chest __________ Rt/Lt Shoulder __________

Rt/Lt Arm __________ Rt/Lt Hip __________ Rt/Lt Leg other __________

What part(s) of the vehicle was damaged? __________

What were the estimated speeds of your vehicle? __________ Other vehicle? __________

What is the estimated cost of the damage to your vehicle? __________

Please describe, to the best of your knowledge, what happened during the accident?

____________________

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Please draw the car accident: