NAME:____ TODAY'S DATE:___________________

ADDRESS:____

Date of Birth:______________________ Home #:________________ Cell #:__________________

Driver's License Number:_____________________________

DATE OF ACCIDENT:___________________ AUTO INSURANCE CO:____________________

INS CO. PHONE NUMBER:_________________ NAME OF AGENT:_______________________

MEDICAL CLAIM #:__________________ INS ADDRESS________________________________

LOCATION OF ACCIDENT:____

TIME OF ACCIDENT:_________ PLEASE DESCRIBE THE ACCIDENT: ___________________
____
____
____

WERE YOU THE __ DRIVER __ PASSENGER __ PEDESTRIAN?

WERE YOU PARKED? __YES __NO

DID YOUR CAR STRIKE THE OTHER(S) INVOLVED? __YES __NO

OR DID THE OTHER CAR STRIKE YOURS? __YES __NO

AS A RESULT OF THE ACCIDENT, WERE TRAFFIC CITATIONS ISSUED TO:

__ YOU __ THE DRIVER OF YOUR CAR __ THE DRIVER OF THE OTHER CAR?

WERE YOU WEARING A SEATBELT? __YES __NO SHOULDER HARNESS ON? __YES __NO

WAS IT: __DAYLIGHT __NIGHT __DUSK __DAWN?

WERE YOU TIRED? __YES __NO WERE YOU AWAKE? __YES __NO

HOW LONG HAD YOU BEEN IN THE CAR? ____

WHERE WERE YOU PRIOR TO THE ACCIDENT? ____

WHAT WERE THE WEATHER CONDITIONS? ____

WHAT WERE THE TRAFFIC CONDITIONS? ____

WHAT WAS THE POSTED SPEED LIMIT? ______ HOW FAST WERE YOU GOING? ______

TYPE OF ROAD: __ TWO LANE __ FOUR LANE __GRAVEL __TAR

DID IT HAPPEN AT A/AN: __ STOP SIGN __TRAFFIC LIGHT __INTERSECTION __HIGHWAY

WERE YOU STRUCK FROM __ FRONT __ BEHIND __ LEFT SIDE __ RIGHT SIDE?

STATE ANY STRANGE EVENTS THAT HAPPENED DURING OR IMMEDIATELY

FOLLOWING THE ACCIDENT:____

____

WHAT DAMAGE WAS DONE TO YOUR CAR?

INSIDE: ____

OUTSIDE: ____

OTHER: ____

IF YOU STRUCK ANOTHER CAR, DID YOU STRIKE THE __FRONT __BACK __SIDE

DID YOUR VEHICLE STRIKE ANYTHING ELSE? ____

WHAT WAS THE DAMAGE TO THE OTHER CAR?

INSIDE: ____

OUTSIDE:____

WHAT TYPE OF VEHICLE WERE YOU DRIVING? MAKE______________________YEAR__________

WHAT CONDITION WAS YOUR VEHICLE IN PRIOR TO THE ACCIDENT? ______________________

WERE YOU COMPLETELY CONSCIOUS AFTER THE ACCIDENT? _____________________________

DO YOU REMEMBER THE IMPACT? ____

HAVE YOU LOST ANY DAYS WORK? __YES __NO DATES:______________________________

DO YOU HAVE AN ATTORNEY ADVISING YOU IN THIS CASE? __YES __NO

IN YOUR OWN WORDS, DESCRIBE YOUR INJURIES OR CURRENT SYMPTOMS: ___________

____

DID YOU HIT ANY PART OF YOUR BODY DURING THE COLLISION? __YES __NO
IF YES, WHICH PART AND HOW? ____

LIST THE EXTENT OF INJURIES AS YOU KNOW THEM: ______________________________
____

DID YOU REQUIRE POST-ACCIDENT HOSPITALIZATION? __YES __NO

DID YOU RECEIVE CARE FROM ANY OTHER HEALTH SPECIALIST? __YES __NO

IF YES, WHAT IS THE SPECIALIST'S NAME:____

CHECK THE SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

__HEADACHE	__DIZZINESS	__DEPRESSION	__FATIGUE
__STOMACH UPSET	__LIGHT BOTHERS EYES	__BUZZING IN EARS	__DIARRHEA
__NECK PAIN	__HEAD SEEMS HEAVY	__LOSS OF MEMORY	__FEET COLD
__NECK STIFF	__PINS & NEEDLES IN ARMS	__EARS RING	__HANDS COLD
__FAINTING	__SLEEPING PROBLEMS	__LOSS OF BALANCE	__BACK PAIN
__FACE FLUSHED	__PINS & NEEDLES IN LEGS	__CONSTIPATION	__TENSION
__NERVOUSNESS	__NUMBNESS IN FINGERS	__LOSS OF SMELL	__FEVER
__IRRITABILITY	__NUMBNESS IN TOES	__LOSS OF TASTE	__CHEST PAIN
__COLD SWEATS	__SHORTNESS OF BREATH	__OTHER	