# AUTO ACCIDENT INFORMATION

♦ ***Date of Accident***: _____ ♦ **Time of Day**: _____

♦ ***What was your position in the vehicle?***

□ Driver □ Front Passenger □ Rear Passenger □ Pedestrian (not in car)

♦ ***How many people were in your vehicle? (including yourself)***

□1 □2 □3 □4 □more than 4

♦ ***What direction were you headed?*** □North □East □South □West

On (name of street) _____

♦ ***What direction was other vehicle headed?*** □North □East □South □West

On (name of street) _____

♦ ***What type of vehicle were you driving?***

□Compact Car □Mid Size Car □Full Size Car □Compact Truck
□Full Truck □Minivan □Full Size Van □Small Sport Utility
□Lg. Sport Util. □Motorcycle □Motor Home □Bicycle

♦ ***What was your vehicle doing just prior to the accident?***

□Stopped at a stop light □Slowing down to a stop □At a complete stop
□Increasing speed □Merging into traffic □Changing lanes

*Traveling at an approximate speed of:*

□5 mph □10 mph □15 mph □20 mph □25 mph □30 mph □35 mph
□40 mph □45 mph □50 mph □55 mph □60 mph □65 mph □70 mph
□75 mph □80 mph □Faster than 80 mph

♦ ***Who hit who?***

□You were struck by another car □You struck another vehicle □You struck a stationary object

♦ ***What was your vehicles point of impact?***

□Front □Rear □Right Side □Left Side
□Right Front □Left Front □Right Rear □Left Rear

♦ ***What was the other vehicle doing just prior to the accident?***

□Stopped at a stop light □Slowing down to a stop □At a complete stop
□Increasing speed □Merging into traffic □Changing lanes

*Traveling at an approximate speed of:*

□5 mph □10 mph □15 mph □20 mph □25 mph □30 mph □35 mph
□40 mph □45 mph □50 mph □55 mph □60 mph □65 mph □70 mph
□75 mph □80 mph □Faster than 80 mph

♦ ***What was the other vehicles point of impact?***

□Front □Rear □Right Side □Left Side
□Right Front □Left Front □Right Rear □Left Rear

♦ ***Your vehicle damage estimate?*** _____

♦ ***Were you wearing seat restraints?***

□Full lap and shoulder restraint □Lap restraint only
□Shoulder restraint only □I was not wearing a restraint

♦ ***What position were your vehicles head rests in?***

□Lowest position □Middle position □Highest Position □No head rest in vehicle

♦ ***Did your vehicles air bags deploy?*** □Yes □No

♦ ***Were you prepared for the impact?***

□Came as complete surprise □Aware and braced for collision □Aware but not braced for collision

♦ ***What position was your head and neck in prior to the impact?***

□Straight forward □Tilted forward □Rotated to the left
□Rotated to the right □Turned around □Toward rear view mirror

♦ ***What happened to your body at the moment of impact?***

□Body was tensed for impact □Body whipped forward/backward □Body torqued and twisted
□Body was thrown over seat □Body was thrown from vehicle □Body was pinned in vehicle
□Body was cut and bruised □Body was thrown from side to side

♦ ***What was your mental/emotional state immediately following?***

□Unconscious □Shaken up □Disoriented □Shaken up & Disoriented

♦ ***Were police notified?*** □Yes □No

♦ ***Did you receive medical attention at the scene of the accident?*** □Yes □No

♦ ***Where did you go immediately following the accident?***

□Hospital □Personal Doctor □This Office □Home □Resumed daily activites
Please list name of hospital/doctor and type of treatment received: _____

♦ ***Did you have any physical complaints before the accident?*** □Yes □No
If yes, please describe in detail: _____

♦ ***What are your present complaints and symptoms?*** _____

_____

*Check symptoms you have noticed since accident:*

| | | | | |
|---|---|---|---|---|
| □Headache | □Irritability | □Numbness | □Face Flushed | □Feet Cold |
| □Neck Pain | □Chest Pain | □Shortness of Breath | □Buzzing in Ears | □Hands Cold |
| □Neck Stiff | □Dizziness | □Fatigue | □Loss of Balance | □Stomach Upset |
| □Sleeping Problems | □Head Seems Too Heavy | □Depression | □Fainting | □Constipation |
| □Back Pain | □Pins & Needles in Arms | □Lights Bother Eyes | □Loss of Smell | □Cold Sweats |
| □Nervousness | □Pins & Needles in Legs | □Loss of Memory | □Loss of Taste | □Fever |
| □Tension | □Numbness in Fingers | □Ears Ring | □Diarrhea | |

□Other _____

♦ ***Since the accident occurred, are your symptoms:*** □Improving □Getting worse □Same

♦ ***Have you ever been involved in an accident before?*** □Yes □No
If yes, please describe, including date(s) and type(s) of accidents, as well as injury(ies) received.

_____