AUTOMOBILE ACCIDENT HISTORY FORM

Your Name:_____ Today's Date: _____

Your auto insurance information:
Insurance company:_____Phone:_____.
Agent/Adjusters Name: _____Claim #:_____.
Attorney's Name:_____Phone:_____.

The **At Fault's** Auto insurance information:
Insurance Company:_____Phone:_____.
Agent/Adjuster's Name:_____Claim #:_____.

Date of Accident: _____ Time of Accident: _____ am/pm

City & Street of Accident: _____

Road Conditions at the time of the accident: **WET DRY ICY OTHER**_____

Did the police come to the accident scene? **YES NO I**s there a report? **YES NO**

Did you go to a 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 this accident? _____
What bruises did you sustain during this accident? _____
Where were **you** seated in the vehicle? _____

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

Did you lose consciousness (black out) upon impact? **YES NO** How long? _____
Did you experience a flash of light or explosion in your head? _____

Did you become **CONFUSED DISORIENTED LIGHT HEADED**
DIZZY NAUSEATED BLURRED VISION RING/BUZZ IN EARS
If you still have some 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

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 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: (please circle)
Slowing down Gaining speed Traveling at a steady rate of speed

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 leg hit _____

Did you receive any injury or bruise from the seat belt? **YES** **NO**
If **YES,** then describe: _____

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

Which of the following car parts broke during the accident? (Please circle)
Windshield front seat back
Right/left side window other _____
Steering wheel other _____

Was the trunk of your body pointed straightforward at the time of the collision?
YES **NO** If no, how was it turned? _____

Was your head pointed straightforward? **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 _____

Was the other vehicle moving at the time of the collision? **YES** **NO**
If yes, what was its approximate speed? _____Mph

If the other vehicle was moving at the time of the collision, was it (please circle):
Slowing down Gaining speed Traveling at a steady speed

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

_____

_____

_____

_____