PRINT CLEAR FORM EMAIL FORM

Auto Accident Information

Name: _____ **Date**: _____
Date of injury: _____ **Time**: _____
Location: _____
_____
Type of vehicles involved: Yours_____ Theirs_____
Speed of vehicles involved: Yours_____ Theirs_____
You were: Driving ☐ Passenger ☐
You were in: Front seat ☐ Back seat ☐
Describe Accident: _____
_____
_____
_____
_____

Were you wearing: Lap belt: Yes ☐ No ☐ Shoulder Harness: Yes ☐ No ☐
Did any of your body strike the inside of the car: Yes ☐ No ☐
Was your head: Facing Forward ☐ Turned right ☐ Turned Left ☐
Looking up ☐ Looking Down ☐
Were the roads: Paved ☐ Gravel ☐ Wet ☐ Dry ☐
Did you anticipate the impact: Yes ☐ No ☐
Did you brace yourself: Yes ☐ No ☐
What was your immediate reaction after the impact? _____
_____
How did you leave the scene: Ambulance ☐ Drove Home ☐
Someone else took me home ☐
Did your symptoms of injuries: Appear immediately ☐ Come on Gradually ☐
Are your symptoms getting worse: Yes ☐ No ☐

Did you receive emergency treatment: Yes ☐ No ☐
Were X-rays taken: Yes ☐ No ☐
If yes, where_____
Emergency room Doctor's name: _____
Were you hospitalized: Yes ☐ No ☐
Did you receive medication: Yes ☐ No ☐
Have you been treated anywhere else for this injury: Yes ☐ No ☐
If yes, where_____

Have you lost time from work as a result of this accident? Yes ☐ No ☐
If yes, where_____

Is this injury covered by insurance? Yes ☐ No ☐
Name of Insurance Company _____Phone #_____
Address _____
Policy #_____ Claim #_____
SS#_____

Name of Attorney (If applicable): _____
Phone #_____
Address _____