Auto Accident Form

Date of Accident:_____ Hour_____ AM ☐ PM ☐ Location:_____

You Were: Driver ☐ Front Seat Passenger ☐ Rear Seat Passenger ☐ - Left ☐ Right ☐ Other ☐

Your estimated speed at moment of accident: Stopped ☐ Slowing ☐ Accelerating ☐

Struck from: Behind ☐ Front ☐ Left ☐ Right ☐ Other ☐

Time of Day: Daylight ☐ Dawn/Dusk ☐ Dark ☐

Road Conditions: Dry ☐ Damp ☐ Wet ☐ Icy ☐ Other ☐

Estimated property damage to your vehicle: $_____ To other vehicle: None ☐ Min ☐ Mod ☐ Major ☐

Were the police on the scene? Y ☐ N ☐ If yes, was a report made? Y ☐ N ☐

Head restraints: None ☐ Integral Type ☐ Adjustable Type- Up ☐ Down ☐ Don't Know ☐

Was the seat altered by the accident? _____ Was the seat broken? _____

Lap Belt: Wearing ☐ No ☐ Don't Know ☐ Shoulder Belt: Wearing ☐ No ☐ Don't Know ☐

Did the air bag deploy? Y ☐ N ☐ If yes, were you struck? Y ☐ N ☐ Hands on wheel? Y ☐ N ☐

Head position: Forward ☐ Left ☐ Right ☐ Up ☐ Down ☐

Did you strike any part of the vehicle? Y ☐ N ☐ If yes, please describe _____

Did you lose consciousness? Y ☐ N ☐ If yes, please describe _____

Did the vehicle strike any objects after crash? Y ☐ N ☐ If yes, please describe _____

Brakes applied? Y ☐ N ☐ N/A ☐ Were you aware of impending crash? Y ☐ N ☐

When did your symptoms first appear? Immediately ☐ _____ Hours after ☐ Which symptom? _____

Have you had similar symptoms previously? Y ☐ N ☐ If yes, please describe _____

Did you go to the hospital following the crash? Y ☐ N ☐

Did you have: X- rays? Y ☐ N ☐ Which body part(s)?_____

Lab Work? Y ☐ N ☐ Medications? Y ☐ N ☐ If yes, list:_____

Have you seen any other doctors concerning this accident? Y ☐ N ☐ If yes, Dr.:_____

Specialty: _____ Date first seen? _____ Currently Treating? Y ☐ N ☐

Treatment type: _____ Frequency: _____ Did it help? Y ☐ N ☐

Special tests? Y ☐ N ☐ If yes, what type? _____

Accident description: _____
_____
_____
_____
_____
_____

Accident Diagram:

Do you have an attorney? Y ☐ N ☐ Phone: _____

Name: _____