

Automobile Accident History Form

Your Name: _____ Today's Date _____

Date of Accident: _____ Time of Accident: _____ A.M. / P.M.

Street of Accident _____ Heading N / S / E / W

City of Accident: _____

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

List the year, make and model of the car you were in:

Year: _____ Make: _____ Model: _____

Was the vehicle you were in stopped at the time of the impact? YES / NO

If yes, was the driver's foot on the brake? YES / NO

If no, then estimate the speed of the vehicle you were in: _____ mph

List 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 the approximate speed? _____ mph

If the other vehicle was moving at the time of the collision, was it:

SLOWING DOWN

SPEEDING UP

TRAVELING AT A STEADY RATE OF SPEED

Which of the following vehicle parts were broken during the accident? _____

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

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

(please turn over)

Where were you seated in the vehicle? _____

Were you aware of the impending collision prior to the impact, or did the impact surprise you? AWARE / SURPRISED

Was the trunk of your body pointed straight forward? YES/ NO

If no, in what direction was it turned? _____

Was your head pointed straight forward? YES / NO

If no, in what direction was it turned? _____

How far is the top of the headrest or seatback from the top of your head (approximately):
_____ inches ABOVE / BELOW.

Were you wearing a seatbelt? YES / NO

If yes, was it a LAPBELT ONLY or SHOULDER AND LAPBELT?

Did the police come to the accident scene? YES / NO; Is there a report? YES / NO

Did you go to the hospital? YES / NO, If yes:

What is the name of the hospital? _____

How did you get there? _____

What parts of your body were X-rayed? _____

What did the hospital do for your injuries? _____

How long did you stay at the hospital? _____

Were there any bleeding cuts sustained in the accident? _____

Were there any bruises sustained in the accident? _____

Did you receive any injury or bruising from your seatbelt? YES / NO

Did you lose consciousness (blackout) upon impact? _____

Did you experience a flash of light or explosion in your head? YES / NO

On what part of the vehicle did your body parts hit? _____

WINDSHIELD

FRONTSEAT

RIGHT/LEFT SIDE WINDOW

STEERINGWHEEL

OTHER _____

Did you become?

CONFUSED

DISORIENTED

LIGHTHEADED

DIZZY

NAUSEATED

BLURRED VISION

RINGING/BUZZING IN THE EARS

Immediately following the accident, if you still have any of these symptoms which are they? _____

Are you currently suffering from any of the following ?

RESTLESSNESS, DIFFICULTY CONCENTRATING, SLEEPLESSNESS, IRRITABILITY,
DIFFICULTY WITH MEMORY, FORGETFULNESS, REDUCED TOLERANCE TO COLD,
REDUCED TOLERANCE TO HEAT OR REDUCED TOLERANCE TO ALCOHOL.