Auto Accident Information

Name_____Date_____Phone ( )_____

Address_____City_____State_____Zip_____

Age_____Birthdate_____Sex_____S/S #_____

Occupation_____Employer's Name_____

Phone (work) ( )_____Driver's License #_____

Nature of Accident:

1. Date of Accident_____ Time of Day_____
2. Were you: ( ) Driver ( )Passenger ( )Front Seat ( )Back Seat
3. Number of People in your vehicle?_____ Where you wearing seat belts? ( )Yes ( )No
4. What direction were you headed? ( )North ( )East ( )South ( )West
   on (name of street)_____
5. What direction was the other vehicle headed? ( )North ( )East ( )South ( )West
   on (name of street)_____
6. Were you struck from: ( )Behind ( )Front ( )Left Side ( )Right Side
7. Approximate Speed of car_____mph Other car_____mph
8. Was your vehicle: ( ) stopped to make a turn ( ) stopped for a traffic signal ( )parked
   ( ) moving at the time of impact ( )Other:_____
9. Are you licensed to drive? ( )Yes ( )No
10. Were you in your own car or someone else's at the time of accident? Check one
    ( )My own vehicle ( )My spouse's ( )My Parents ( )a Friend's ( ) other
    If you were in someone else's at the time of accident, answer the following:
    Name of Owner:_____
    Address of Owner:_____
    Phone # of Owner ( )_____
11. Were the police notified? ( )Yes ( )No
12. Do you have a copy of the police report? ( )Yes ( )No

13. Who received the ticket or citation?_____

14. Do you have any "courtesy slips" or other information concerning the other parties involved In the accident? ( )Yes ( )No

15. In your own words, please describe the accident:_____

_____
_____
_____

Symptoms After Accident:

1. Were you knocked unconscious? ( ) Yes ( )No
2. Were you looking: ( )Straight Ahead ( )To the Left ( )To the right
3. Have you been x-rayed since the accident? ( )Yes ( )No
4. Did you have any physical complaints BEFORE THE ACCIDENT? ( )Yes ( )No

_____
_____
_____

5. Please describe how you felt:
   a. DURING the accident:_____
   b. IMMEDIATELY AFTER:_____
   c. LATER THAT DAY:_____
   d. THE NEXT DAY:_____

6. What are your PRESENT complaints and symptoms?_____

_____
_____

7. Do you have any congenital (from birth) factors which relate to this problem? ( )Yes ( )No
   If yes, please describe:_____
8. Do you have any previous illnesses, which relate to this case? ( )Yes ( )No
9. Since the accident occurred, are you symptoms: ( )Improving ( )Getting Worse ( )Same
10. CIRCLE THE SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT

Headache	Irritability	Numbness in Toes	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
Depression	Fainting	Constipation	Back Pain	Cold Sweats
Loss of Memory	Loss of Taste	Loss of Smell	Nervousness	Ears ringing

11. Do you notice any activity restrictions as a result of this injury? ( )Yes ( )No
    If yes, please describe:_____

_____
_____

Insurance Information

1. Insurance Company Name:_____
   Policy Number:_____
   Phone Number:_____

2. Have you been contacted by an adjuster from the other party's insurance company regarding this claim? ( )Yes ( )No

   Name of Adjuster:_____
   Phone Number:( )_____

3. Have you lost time from work as a result of this accident? ( )Yes ( )No
   a. Last day worked:_____
   b. Type of Employment:_____
   c. Present Salary:_____
   d. Are you being compensated for time lost from work? ( )Yes ( )No