AUTOMOBILE ACCIDENT HISTORY FORM

(Please fill in the appropriate information and/or circle the most appropriate answer.)

Your Name: _____ Today's Date: _____

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

City and Street(s) of Accident: _____

Road conditions at time of accident: WET DRY ICY Other: _____

Did police come to the scene? YES NO Is there a report? YES NO UNKNOWN

Did you go to the 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 the impact catch you by surprise?
- Aware: _____ Surprised: _____

Did you lose consciousness (black out) upon impact? Yes No If yes, for how long? _____
Did you experience a flash of light or explosion in your head? Yes No
Did the accident cause you to be/have (circle all that apply):

CONFUSED	NAUSEATED
DISORIENTED	BLURRED VISION
LIGHT HEADED/DIZZY	RING/BUZZ IN EARS

If you still have any of those symptoms, which ones are they? _____

Are you presently suffering from any of the following (circle all that apply):

RESTLESSNESS	IRRITABILITY
DIFFICULTY CONCENTRATING	MEMORY PROBLEMS
SLEEPLESSNESS	FORGETFULNESS
REDUCED TOLERANCE TO HEAT	REDUCED TOLERANCE TO ALCOHOL

How far is the top of the headrest or seat back from the top of your head?
(approximately): _____ inches ABOVE or BELOW

Were you wearing a seatbelt? YES NO Was it a LAP BELT and/or SHOULDER BELT?

List the year, make and model of the vehicle that you were in:
Year _____ Make _____ Model _____

Was your vehicle stopped at the time of impact? YES NO
If yes, was the driver's foot also on the brake? YES NO
If no, estimate the speed of the vehicle that you were in: _____ km/h.

If your vehicle was moving at the time of impact, was it:
slowing down? YES NO
gaining speed? YES NO
travelling at a steady rate of speed? YES NO

Did your body strike any parts of the vehicle? YES NO If yes, describe: _____
_____

Did you receive any injury or bruise from the seatbelt? YES NO If yes, describe: _____
_____

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

Which parts of your car were damaged during the accident?
WINDSHIELD STEERING WHEEL Other _____
R/L SIDE WINDOW FRONT SEAT BACK Other _____

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

Was your head pointed straight forward at the time of the collision? YES NO
If no, what direction was it turned and by how much? _____

What was the year, make and model of the other vehicle:
Year _____ Make _____ Model _____

Was the other vehicle moving at the time of impact? YES NO
If yes, what was its approximate speed? _____ km/h.

If the other vehicle was moving at the time of impact, was it:
slowing down? YES NO
gaining speed? YES NO
travelling at a steady rate of speed? YES NO

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