AUTOMOBILE ACCIDENT INFORMATION

What was the date of the accident? _____ How many vehicles were involved? _____
What was the estimated damage to the vehicle you were in? _____
What city and state did the accident occur in? _____
What street or intersection were you on when the accident occurred? _____
What direction were you traveling in? _____
What type of impact was the auto accident? ☐ Front ☐ Behind ☐ Driver's side ☐ Passenger Side
Did your vehicle hit anything after the accident? if yes, please describe _____
Where were you sitting in the vehicle during the accident? ☐ Driver's seat ☐ Passenger Seat ☐ Rear Seat
Did you know the accident was coming? _____
Type of vehicle you were in? _____ Type of vehicle which impacted yours? _____
At the time of the impact, how fast was your vehicle moving? _____ Other vehicle speed? _____
During and after the crash what happened to your vehicle? (Check all that apply) ☐ kept going straight
☐ spun around ☐ Hit a car in front ☐ Spun around and hit a stationary object ☐ Was hit by another vehicle
☐ hit a stationary object ☐ Other _____
Did you lose consciousness during the accident? ☐ yes ☐ no
How was your head positioned during the accident? Looking ☐ Up ☐ Down ☐ Right ☐ Left ☐ Back
How was your torso positioned during the accident? _____
How were your hands positioned during the accident? _____
Did you strike anything in the vehicle at impact? (Check all that apply) ☐ Head ☐ Face ☐ Shoulder ☐ Chest
☐ Hips ☐ Knees ☐ Feet ☐ Glasses thrown from you face
Is your headrest in your vehicle? ☐ Adjustable ☐ Non-movable ☐ No headrest
Where was the headrest positioned on your head? _____
Did you have your seatbelt on? - Yes –No Did you slide out of your seatbelt during the accident? _____
What was damaged on your vehicle? (Check all that apply) ☐ Windshield ☐ Rear bumper ☐ Mirror ☐ Steering wheel ☐ Front bumper ☐ knee bolster ☐ Dashboard ☐ Trunk ☐ Back right door ☐ Seat frame
☐ Front left door ☐ Completely totaled ☐ Side window ☐ Front right door ☐ Rear window ☐ Back left door
Any doors as a result of the accident that would not open ☐ front left ☐ Front right ☐ Rear left ☐ Rear right

Did you go to the hospital? Yes No If no Skip to Auto Insurance Information
How did get to the hospital? ☐ Ambulance ☐ Drove yourself ☐ Driven by friend Name of the hospital? _____
_____ Were you hospitalized overnight? ☐ Yes ☐ No
Check what you were prescribed at the hospital: ☐ Pain medication ☐ Muscle relaxers ☐ neck brace ☐ Other
_____
Did you receive any stitches for any cuts at the hospital? _____ Were x rays taken at the hospital? If yes, which area was taken? _____

Auto Insurance Information

As a result of the accident where traffic citations issued? ☐ No If yes to: ☐ Driver of your car ☐ Other driver
Have you been contacted by the adjuster or company representative regarding this claim? ☐ Yes ☐ No
If yes, Name: _____ Phone number: _____
Name of owner / Driver of Vehicle in which you were injured: _____
Name of Auto Insurance Company: _____Policy#: _____
Claim #: _____ Name of Insurance Adjuster: _____ Phone #: _____
If you have an Attorney Representing, you for this accident what is their name? _____
Phone number: _____ Address: _____

Patient Signature:_____ Date: _____