AUTOMOBILE ACCIDENT INFORMATION

Date of the accident? _____ How many vehicles were involved? _____
The estimated damage of your vehicle? _____ □ Totaled
City and state where the accident occurred? _____
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 when the vehicle? □ Driver's seat □ Passenger Seat □ Rear Seat
Did you know the accident was coming? □ Yes □ No Did you have time to brace yourself? □ Yes □ No
Type of vehicle you were in? _____ Type of vehicle which impacted yours? _____
How fast was your vehicle moving? □ Stopped □ Slowing □ Accelerating □ Doing speed limit
During and after the crash, what happened to your vehicle? (Check all that apply)
□ Was pushed forward □ spun around □ Hit the vehicle in front □ Spun around and hit a stationary object
□ Was hit by another vehicle □ hit a stationary object □ Other _____
Did you lose consciousness? □ Yes □ No Were you aware of all the events immediately after? □ yes □ no
How was your head positioned during the accident? □ Looking Up □ Down □ Right □ Left □ Back □ at side mirror □ At review mirror □ Other _____
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 □ Hands □ Glasses were thrown from your face
Is your headrest in your vehicle? □ Adjustable □ Non-movable □ No headrest
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 you get to the hospital? □ Ambulance □ Drove yourself □ Driven by friend Name of the hospital? _____ Were you hospitalized overnight? □ Yes □ No
Were prescribed?: □ 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? □ Neck □ Mid-back □ Low back Other: _____

Auto Insurance Information

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: _____

Signature: _____ Date: _____

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