Auto Accident Form

Full Name:_____ Today's Date:____/____/____

Date & Time of Accident:_____ A.M P.M Were you the: Driver Front Passenger Rear Passenger
(circle one) (circle one)

If a traffic violation was issued, to whom was it issued?_____

(circle one)

Did the police come to the accident site? ……..Yes or No Number of people in the accident

Was a police report filed?.....Yes or No vehicle?_____

Were there any witnesses?.....Yes or No

Were you wearing your seatbelt?.....Yes or No

Was the vehicle equipped with airbags?.....Yes or No

If yes, did it/they inflate?.....Yes or No

In relation to the base of your skull, where was the headrest? Above Below At base of skull
(circle one)

What did your vehicle impact? Another vehicle Other If other, please explain_____

_____

Did any part of your body strike anything in the vehicle? Yes or No If yes, please explain_____

_____

Make & Model of the vehicle you were occupying?_____

Name of the location/street on which you were traveling?_____

In which direction were you headed? North South East West
(circle one)

What was the approximate speed of your vehicle? _____mph

Did the impact to your vehicle come from the : Front Rear Right side Left side Other
(circle one)

During impact, what direction were you facing?_____

Were you aware or surprised by the impact? Please explain:

_____

If accident vehicle made impact with another vehicle, what was the Make & Model of the other vehicle?_____

_____ Direction this vehicle was headed: North South East West

Speed of the other vehicle? _____mph (circle one)

Was there a lot of damage to your vehicle? Please explain: _____

_____

In your words please describe the accident:_____

_____

_____

_____

Did the accident render you unconscious? Yes or No If yes, for how long?_____

Please describe how you felt immediately after the accident:_____

_____

_____

Have you gone to the Hospital or any other Doctor? Yes or No If yes, when?_____

Did you drive yourself(or family member/friend) or did you travel by ambulance? _____

Name of Hospital and/or Attending Doctor:_____

Was he/she a: D.C M.D D.O D.D.S Describe treatment received:_____

_____

Were X-rays taken? Yes or No Was medication prescribed? Yes or No If yes, what: _____

Have you been able to work since the accident? Yes or No

Are your activities restricted as a result of the accident? Yes or No

Please check all symptoms that are a result of this accident:
__Dizziness __Difficulty sleeping __Jaw problems __Nausea __Memory loss __Irritability
__Leg pain __Arm/shoulder pain __Headaches __Fatigue __Numb hands/fingers
__Tension __Lower back pain __Chest pain __Neck pain/stiffness __Buzzing in ear(s)
__Ear ringing __Stomach upset __Numb feet/toes __Shortness of breath __Blurred vision
__Back pain/stiffness __Other:_____

Is your condition getting worse? Yes No Constant Comes and goes
(circle one)

Indicate your degree of comfort while performing the following activities:

Activity/Position	Comfortable	Uncomfortable	Painful
Lying on back			
Lying on side			
Lying on stomach			
Sitting			
Standing			
Stretching			
Lovemaking			
Walking			
Lifting			
Bending			
Kneeling			
Pulling			
Reaching			
Driving			

*Mark those that apply even if it is only sometimes.

Have you retained an attorney Yes or No If yes, whom:_____
His/ Her Phone Number ( )_____-_____

To evaluate the effect that continuing work will have on your recovery please complete the following:
How many hours are in your normal work day?_____
Please mark your daily job duties and any activities which you are occasionally asked to perform:
___Standing ___Driving ___Operating equipment ___Sitting ___Twisting ___Work with arms above head
___Walking ___Crawling ___Typing ___Lifting ___Bending ___Stooping
___Other:_____
What positions can you work in with minimum physical effort and for how long?_____ __N/A
Prior to the injury were you capable of working on an equal basis with others your age? Yes No N/A
Do you work with others your age? Yes No N/A
While in recovery, is there any light duty work you could request? Yes No N/A

Additional Insurance: Second insurance source or auto insurance.
Company Name:_____ Policy/Claim #:_____
Address:_____ Phone #:( )_____-_____
Insured's Name:_____ DOB:____/____/____ Agent's Name:_____

If any of your medical or account information has changed, please inform our front desk personnel.
Please remember you are ultimately responsible for your account.

_____ _____/_____/_____
SIGNATURE DATE