

Automobile Accident Information

Name: _____ Today's Date: _____

Date of Accident: _____ Time of Accident: _____ Location of Accident: _____

City, State and County where accident occurred: _____

Describe how accident happened in detail: _____

In the accident:

Were you the Driver Passenger Pedestrian Other

Were you using a seatbelt? Yes No

If yes, was it a: Lap seatbelt Shoulder-lap seatbelt

Were you struck from Behind Front Left Side Right Side

Road Conditions Wet Dry Icy Other

Did Air Bag Deploy: Yes No

Did you receive any injuries or bruising from the seatbelt or air bag? Yes No

What was the position of your head at the time of the collision? Straight Ahead Turned Right Turned Left

Did your body hit anything in the car? Yes No What? _____

List any body areas that made contact with the vehicle parts: _____

Did you lose consciousness? Yes No How long? _____

Where did you feel pain immediately after the accident? _____

Did you go to the hospital? Yes No

List the extent of your injuries: _____

Check the symptoms you have noticed since the accident:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Digestive Trouble | <input type="checkbox"/> Loss of Smell |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Arm/Shoulder pain | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Loss of Taste |
| <input type="checkbox"/> Neck Pain/Stiff | <input type="checkbox"/> Eyes Sensitive to Light | <input type="checkbox"/> Depression | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Head feels too heavy | <input type="checkbox"/> Leg Pain | <input type="checkbox"/> Broken Bones |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Pins & Needles in arms | <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Cold Feet |
| <input type="checkbox"/> Jaw Problems | <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Ears Ringing | <input type="checkbox"/> Cold Hands |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Pins & Needles in legs | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Low Back pain |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Numbness: _____ | <input type="checkbox"/> Upper Back pain | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Bruises | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Nauseated |
| <input type="checkbox"/> Light Headed | <input type="checkbox"/> Disorientated | <input type="checkbox"/> Pain behind eyes | <input type="checkbox"/> Mid Back pain |

Since the injury, are your symptoms Improving Worsening

Do you have automobile insurance? Yes No

Insurance Company _____ Policy # _____ Claim # _____

Have you contacted your insurance company? Yes No

Have you turned in your P.I.P (Personal Injury Protection) Application? Yes No

Have you retained an attorney? Yes No

Attorney's Name _____ Attorney's Firm Name _____

Address: _____ Phone # _____