

AUTOMOBILE ACCIDENT HISTORY FORM

Your Name: _____ Today's Date _____

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

City of Accident: _____ Street of accident: _____

Road conditions at the time of the accident: WET DRY ICY OTHER

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

Did you go to a 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 impact catch you by surprise?

AWARE SURPRISE

Did you lose consciousness (black out) upon impact? YES NO; How long: _____

Did you experience a flash of light or explosion in your head? YES NO

Did you become: CONFUSED DISORIENTED LIGHTHEADED
DIZZY NAUSEATED BLURRED VISION RING/BUZZ IN EARS
from the accident? (please circle)

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

Are you currently suffering from any of the following (please circle):

RESTLESSNESS

IRRITABLE

DIFFICULT CONCENTRATING

DIFFICULT WITH MEMORY

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 (approx.):

_____ inches above or below Were you wearing a seatbelt? YES NO

If yes, was it a lap seatbelt _____ or shoulder-lap seatbelt _____.

List the year, make and model of the vehicle you were in:

year _____ make _____ model _____

Was your car stopped at the time of impact? Yes No

If yes, was the brake applied? Yes No

If no, then estimate the speed of the vehicle you were in: _____ mph

If your vehicle was moving at the time of impact, was it:

slowing down? Yes No

gaining speed? Yes No

traveling at a steady rate of speed? YesNo

On what part of the automobile did your following body parts hit?

head hit _____ chest hit _____

right/left shoulder hit _____ right/left arm hit _____

right/left hip hit _____ right/left leg hit _____

right/left knee hit _____ other _____

Did you receive any injury or bruise from the seat belt? Yes No

if YES, then describe: _____

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

Which of the following car parts broke during the accident? (please circle)

windshield front seat back right/left side window steering wheel

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? YES NO; If no, what direction was it turned and by

how much? _____

What is the year, make and model of the other vehicle?

year _____ make _____ model _____

Was the other vehicle moving at the time of the collision? YES No

If yes, what was its approximate speed? _____ mph

If the other vehicle was moving at the time of the collision, was it (please circle);

slowing down gaining speed traveling at a steady speed

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

accident: _____
