Automobile Accident Form

Name _____ Date of Birth _____ Phone _____

Address _____ City _____ State _____ Zip _____

Employer's Name _____ Employer's Address _____

Your Ins. Co. _____ Policy # _____

Agent's Name _____ Claim # _____

Have you retained an attorney? ( ) Yes ( ) No Name _____

Were there any witnesses? ( ) Yes ( ) No Name(s) _____

Nature of Accident:

1. Date of Accident: _____ Time of Day _____
2. Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat
3. Number of people in your vehicle? _____ Other Vehicle? _____
4. What direction were you headed? ( ) North ( ) East ( ) South ( ) West
   on (name of street) _____
5. What direction was the other vehicle headed? ( ) North ( ) East
   ( ) South ( ) West
   on (name of street) _____
6. Were you struck from: ( ) Behind ( ) Front ( ) Left side ( ) Right side
7. Were you knocked unconscious? ( ) Yes ( ) No. If yes, for how long? _____
8. Were police notified? ( ) Yes ( ) No
9. In your own words, please describe accident: _____

_____

_____

10. Did you have any physical complaints BEFORE THE ACCIDENT?( )Yes ( ) No
    If yes, please describe in detail:

_____

_____

_____

11. Please describe how you felt:
    a. DURING the accident: _____

    b. IMMEDIATELY AFTER the accident: _____

    c. LATER THAT DAY: _____

    d. THE NEXT DAY: _____

12. What are your PRESENT complaints and symptoms? _____

_____

13. Do you have any congenital (from birth) factors which relate to this problem?
( ) Yes ( ) No. If yes, please describe: _____

14. Do you have any previous illnesses which relate to this case? ( ) Yes ( ) No
If yes, please describe: _____

15. Have you ever been involved in an accident before? ( ) Yes ( ) No. If yes, please describe, including date(s) and type(s) of accidents, as well as injuries received.

16. Where were you taken after the accident? _____
17. Have you ever been treated by another doctor since the accident? ( ) Yes ( ) No.
If yes, please list doctor's name and address: _____

What type of treatment did you receive? _____

Since this injury occurred, are your symptoms:
( ) Improving ( ) Getting Worse ( ) Same

19. CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

☐ Headache ☐ Irritability ☐ Numbness in Toes ☐ Face Flushed
☐ Feet Cold ☐ Neck Pain ☐ Chest Pain ☐ Shortness of Breath
☐ Buzzing in Ears ☐ Hands Cold ☐ Neck Stiff ☐ Dizziness ☐ Fatigue
☐ Loss of Balance ☐ Stomach Upset ☐ Sleeping Problems
☐ Head seems Too Heavy ☐ Depression ☐ Fainting ☐ Constipation
☐ Back Pain ☐ Pins & Needles in Arms ☐ Lights Bother Eyes
☐ Loss of Smell ☐ Cold Sweats ☐ Nervousness
☐ Pins & Needles in Legs ☐ Loss of Memory ☐ Loss of Taste
☐ Fever ☐ Tension ☐ Numbness in Fingers ☐ Ears Ring
☐ Diarrhea

Symptoms Other Than Above _____

20. Have you lost time from work as a result of this accident? ( ) Yes ( ) No.
If yes, please complete this question.
a. Last Day Worked: _____
b. Type of Employment: _____

c. Are you being compensated for time lost from work? ( ) Yes ( ) No.
If yes, please state type of compensation you are receiving? _____
21. Do you notice any activity restrictions as a result of this injury?( ) Yes ( ) No.
If yes, please describe, in detail: _____

22. Other pertinent information: _____

_____
Signature

_____
Date: