

AUTO ACCIDENT REPORT

Name_____ Age_____
Employer _____ Occupation _____
Did this accident occur while on the job? ( ) Yes ( ) No

Did you have automobile insurance coverage at the time of the accident? ( ) Yes ( ) No
Have you reported this accident to your insurance carrier? ( ) Yes ( ) No
Your Insurance Company _____
Claim # _____ Address _____
Adjuster's Name _____ Adjuster's phone number_____
Do you have an attorney representing you? _____ Name _____

Date of Accident _____ Time of Day _____ (a.m.) (p.m.)
Were you ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat
Number of people in your vehicle? _____ Type of Vehicle_____
What direction were you headed ( ) North ( ) South ( ) East ( ) West
Name of street_____ At what speed were you traveling? _____
Type of other vehicle involved _____ How fast was the other vehicle going?_____
Were you wearing a seat belt? ( ) Yes ( ) No With a shoulder strap? ( ) Yes ( ) No

Indicate if your body hit something or was hit by any of the following.
(Draw lines and match the left side to the right side.)

Head	Windshield
Face	Steering Wheel
Shoulder	Side Door
Neck	Dashboard
Chest	Car Frame
Hip	Another Occupant
Knee	Seat
Foot	Seat Belt
	Other_____

Does your vehicle have…
( ) Movable head restraints
( ) Fixed, non-movable head restraints
( ) No head restraints
Please indicate how your head restraint was positioned at the time of the crash
( ) At the top of the back of your head
( ) At the top of the back of your head
( ) Midway height of the back of your head
( ) Lower height of the back of your head
( ) Located at the level of your neck
( ) Located at the level of your shoulder blades (below neck)
Please describe the accident _____
_____
_____
_____
_____
Describe the condition of your car after the accident _____
_____
_____

AUTO ACCIDENT REPORT

Describe how you felt…

During the accident _____

Immediately after the accident _____

Later that day _____

The next day or two _____

What are your present complaints _____

_____

Did you go to the emergency department after the accident? ( ) Yes ( ) No

If not, when did you go? _____ Which hospital? _____

Did you go by ( ) ambulance ( ) someone else drove me ( ) drove myself

Did you have x-rays taken? ( ) Yes ( ) No

( ) Skull ( ) Neck ( ) Low-back ( ) Upper back/chest

( ) Arm / Elbow / Hand ( ) Leg / Knee / Foot ( ) Other _____

Did the doctor give you pain medications? ( ) Yes ( ) No Muscle relaxants? ( ) Yes ( ) No

What other treatment was given? _____

Have you sought other medical help? ( ) Yes ( ) No

If you did not see a doctor for the first time within the first month after injury, indicate why. (Check all that apply.)

( ) No pain was noticed
( ) No transportation
( ) I thought the pain would go away
( ) I self-treated with over-the-counter drugs
( ) No appointment schedule available
( ) Work / home schedule conflicts
( ) I had no insurance or money
( ) I toot hot showers / used ice / used heat

Have you been unable to work since the injury? ( ) Yes ( ) No

If yes, were you off work ( ) partially or ( ) completely

Please list date(s) off work: _____to _____.

(Women) Are you pregnant? ( ) Yes ( ) No Nursing? ( ) Yes ( ) No

Please list all medications you are currently taking: _____

_____

Have you ever been involved in an accident before? ( ) Yes ( ) No

Major traumas? _____

_____

Did you have symptoms prior to this accident? ( ) Yes ( ) No

Have you ever suffered from any of your current symptoms before? ( ) Yes ( ) No

If so, when? _____

Signature _____ Date _____