AUTOMOBILE ACCIDENT HISTORY

Name:____ Today's Date:_________________________________

ACCIDENT HISTORY:

Date of the Accident:_____________________________________ Time of the Accident_________________ [ ] AM [ ] PM

In what State did the Accident Happen? [ ] Ohio [ ] Kentucky [ ] Indiana [ ] Other, please state____________________

Describe in detail how the Accident happened ____

____

____

____

Seat Belt on? [ ] Yes [ ] No Shoulder Harness On? [ ] Yes [ ] No

Did the Airbag deploy? [ ] Yes [ ] No Were you? [ ] Surprised by the impact [ ] Brace for the impact

Were you driving?__________ Was it your car?___________ If not, who's:_______________________________________

If you were driving….

Were both hands on the steering wheel? [ ] Yes [ ] No, If NO, which hand was on the wheel? [ ] Right [ ] Left

Was your foot on the brake? [ ] Yes [ ] No Were you looking [ ] Straight Ahead [ ] Left [ ] Right [ ] Up [ ] Down

If you weren't driving…. where were you sitting?

[ ] Front passenger [ ] In the back on the Driver's side [ ] Back Middle Seat [ ] Back Passenger side

Were you rotated in your seat?____

Was it Daylight?_________________ Night?________________ Dusk?________________ Dawn?____________________

How fast were you going?___________mph How fast was the other vehicle going?_________mph

Was the car hit from: Front_________ Back________ Left Side (Drivers)____________ Right Side (Passenger)_________

What damage was done to your car? Inside____

Outside?____

What damage was done to the other vehicle? Inside____

Outside?____

What type of vehicle were you driving? Make_______________________ Model______________________ Year_______

What other type of vehicle was involved in the accident? [ ] Car [ ] Truck [ ] Motorcycle [ ] Semi-Truck

Was a police report made? [ ] No [ ] Yes If yes, which police dept.____

Who was ticketed? [ ] Me [ ] The Other Person [ ] No One

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Name:____ Today's Date:______________________________

Did you hit any part of your body during the collision, for example, head on dash, chest on steering wheel? [ ] Yes [ ] No

If yes, Which part and how?____

Were you completely conscious after the impact?_______________ Do you remember the impact?___________________

Where did you go after the accident? [ ] Hospital [ ] Work [ ] Home [ ] Other_________________________________

If you went to the hospital, what Hospital?____

What care did you receive?____

____

____

Did you receive care from any other health care professional other than the ER or Hospital? [ ] Yes [ ] No

If yes, whom did you receive care from____

What type of care were you given and for how long?____

____

How did you respond to any of the above treatment? [ ] Improved [ ] About the same [ ] Got worse

Have you ever been injured in a similar manner?_________ If yes, how and when?_________________________________

____

____

Does it bother you to ride in a car now?________________ Is so, as a Driver?______________ Passenger_______________

State any strange events that happened during or immediately after the accident.__________________________________

____

Have you had any time loss from work? [ ] No [ ] Yes, If yes, how long?____

Are you currently working?___________________________ Are your working with restrictions?_______ If so what are they____

Prior to the accident, were you able to work on an equal basis with other your age? [ ] Yes [ ] No, If no, please explain

____

____

Since the accident, have your symptoms? [ ] Gotten Better [ ] Stayed the Same [ ] Gotten Worse

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Name:____ Today's Date:_______________________________

Auto Insurance Information:

Your Auto Insurance Company?____

Claim #:____

Your Auto Insurance Adjuster:____

Phone #:____

Other Person's Insurance Company?____

Claim #:____

Adjuster for Other Insurance Co.:____

Phone #:____

Attorney Name:____

Attorney Firm:____

Phone #:____