HISTORY OF AUTOMOBILE ACCIDENT

Name: _____ Age: _____ □ M □ F

Your Auto Insurance: Do you have PIP coverage? □ Yes □ No Limits: $_____

Your (or your car's driver) Insurance Company: _____

Policy # _____ Claim # _____

If another driver was at fault: His/her Insurance Company: _____

Policy # _____ Claim # _____

Do you have an attorney? □ Yes □ No Name: _____

DESCRIPTION OF THE ACCIDENT:

Date of accident: _____ Time of the accident: _____ □ A.M. □ P.M.

Street / Intersection / Highway: _____

City of Accident: _____ Road conditions: □ Dry □ Wet □ Snowy □ Icy

Were you at: □ Stop light □ Stop Sign □ Turn lane □ Parking lot □ Freeway
□ Intersection □ Other: _____

How was the traffic? □ Light / normal □ Heavy □ Stop and go

At time of impact, your car was: □ Stopped □ Braking □ Backing up □ Driving forward

Speed limit: _____ Speed of your car? _____ Estimated speed of other car? _____

Describe what happened in the accident: _____

_____

_____

_____

Where on your car was the impact? □ Front □ Back □ Right side □ Left side

Were you wearing seat belt? □ Yes □ No Did air-bags deploy? □ Yes □ No

Did your body strike anything in the car? □ Yes □ No What, and with which body part? (dashboard, steering wheel, head rest, side window, etc.) _____

_____

(Continued on back)

Were you blacked out/unconscious after the impact? □ Yes □ No How long? _____

Did you go to: □ Hospital / ER □ Urgent Care □ Doctor's office

How did you get there? □ Ambulance □ Family/friend drove □ Drove yourself

When? □ Immediately □ Later in day □ Next day □ Other: _____

Were x-rays taken? □ Yes □ No Of which parts of the body? _____

What was the diagnosis? _____

Which did they do (prescriptions or referral given, etc.) _____

Since the accident, where have you had pain? □ Neck □ Headaches □ Upper back
□ Mid back □ Low back □ Chest/ribcage □ Shoulder (R or L) □ Elbow (R or L)
□ Wrist/hand (R or L) □ Down arm (R or L) □ Down leg (R or L) □ Hip (R or L)
□ Knee (R or L) □ Ankle/foot (R or L) □ Other _____

_____

Were you having any of these pains or problems prior to this accident? □ Yes □ No

Where? _____

Were you driving? □ Yes □ No Was this your car? □ Yes □ No – Whose? _____

If passenger, where were you sitting? □ Front □ Back □ Right □ Left Other _____

Were other people in the car? □ Yes □ No Who? _____

Were they hurt? □ Yes □ No Explain:_____

What was the make/model/year of <u>your</u> vehicle? _____

What was the make/model/year of <u>the other</u> vehicle? _____

How much damage to your car? _____

How much damage to other car? _____

Did the police come? □ Yes □ No Was a ticket issued? □ To you □ To other driver

Who was at fault? □ You □ Other driver □ Other: _____

Have you missed time from work? □ Yes □ No How long? _____