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Motor Vehicle Accident History Form

Name: _____ Today's Date: _____

Your auto insurance company_____ Policy No. _____Claim No._____

Claim Representative Name: _____ Representative phone number: _____

Date of Accident: _____ Hour: _____ a.m./p.m. Location of accident (city): _____

Type of vehicles involved in accident (ie: car, truck, suv, etc.) _____

Did the police come to the accident scene? □ Yes □ No

Was a citation issued? □ Yes □ No. For what reason?_____

Did the crash occur while on the job? □ Yes □ No

Please describe to the best of your ability what happened during this accident: _____

_____

_____

_____

BEFORE & DURING THE IMPACT

Were you the: □ Driver □ Front Passenger Rear Passenger

Were you wearing a seatbelt? □ Yes No. Did it hold during the impact? □ Yes □ No

Did the airbag inflate? □ Yes No

Did your seat have a headrest? □ Yes No

The top of the headrest was: □ Below □ Even with □ Above the top of my head

Were brakes applied? □ Yes □ No

If moving, estimated speed of your car was: _____ MPH. The other vehicle(s) _____ MPH

Road conditions at the time of the accident were: □ Wet Dry Icy Loose Gravel □ Other _____

Visibility at the time of accident: □ Clear □ Cloudy □ Foggy □ Other: _____

Were there any obstructions involved (example: blind corner, parked vehicle, etc)? _____

At impact were you: □ Surprised □ Braced for it

CONCERNING YOU

After impact did you feel: □ OK Confused □ In Pain □ Emotional □ Nauseated □ Had a headache

Did you have time to brace yourself? _____

How were you sitting before impact (turned to the right / left / straight ahead, etc)? _____

What position were you in following the impact? _____

Did you try to grab or restrain anyone? □ Yes □ No

Did you lose consciousness (blackout) upon impact? □ Yes □ No. If Yes, how long? _____

Did you see stars, bright white lights, or did you feel a blinding or explosive sensation in your head? □ Yes □ No

What bleeding cuts did you receive during the accident? _____

Were you thrown about inside the vehicle? □ Yes □ No. On what part of the vehicle did the following body parts hit?:

Head: _____ *Chest/Back:* _____

Right/Left Shoulder: _____ *Right/Left Knee:* _____

Right/Left Hip: _____*Right/Left ankle, foot:* _____

Right/Left arm, elbow, wrist, hand: _____*Other:* _____

Did any object in the car hit you? □ Yes □ No _____

Were you taken to the hospital? □ Yes □ No. By ambulance? □ Yes □ No. Hospital Name _____

Were □ X-rays □ MRI □ CT Scan etc, □ Lab work performed?

Were you given any special instructions and/or medications? _____

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Name: _____ Today's Date: _____

CONCERNING YOUR VEHICLE

Was the impact from: □ Front □ Rear □ Left □ Right

Make, year & Model of vehicle your were in: _____

Did your car strike the other(s) did the other car strike yours? _____

Compared to your car, was the other vehicle: □ Bigger Smaller □ The same size

Was the road surface: □ Dry □ Wet □ Icy □ loose gravel □ pavement □ Dirt □ Mud

The collision moved your vehicle: □ a little □ more than a little □ a lot

Your vehicle was: □ Stopped □ Slowing Accelerating

What part of your car was damaged: □ Front □ Driver's side □ Passenger's side □ Rear

CONCERNING PREVIOUS ACCIDENTS

How many prior accidents involving cars have you had: _____

How many accidents *not* involving cars? ____

Did you get hurt in those? □ Yes □ No

Are all your symptoms today due to this accident? □ Yes □ No. Explain: _____

_____