

Automobile Accident Information

Name _____ Today's Date _____

Age _____ Date of Accident _____

Were you the Driver Front passenger Rear passenger

If a ticket was issued, to whom was it issued? _____

Number of people in accident vehicle _____

Did the police come to the accident site? YES NO
Was a police report filed? YES NO
Were there any witnesses? YES NO
Were you wearing a seatbelt? YES NO
Was vehicle equipped with airbags? YES NO
If yes, did they inflate? YES NO
What did your vehicle impact? Another vehicle Other
If other, explain:

Did any part of your body strike anything in the vehicle? YES NO
If yes, please describe:

Year, make and model of the vehicle you were occupying _____

Year, make and model of the other vehicle _____

Did impact come from: Front Rear Right side Left side
Were you facing: Forward Right Left
Were you: Aware or surprised by the impact

In your words, describe the
accident: _____

Were you knocked unconscious? _____ If yes, for how long? _____

Have you gone to a hospital or seen any other doctor since the accident? _____

When did you go? Just after the accident The next day 2 days plus

How did you get there? Ambulance or private transportation

Name of Hospital or doctor: _____

Was he/she a M.D. D.C. D.O.

Were X rays taken? _____ Of what body parts? _____

Did you have MRI or CAT Scan? _____ Of what body part? _____

Was medication prescribed? _____ If you know, what
medications? _____

Have you missed any work because of this accident? _____

Have you ever been in any previous auto accidents? _____ When? _____