# AUTOMOBILE ACCIDENT HISTORY

## PERSONAL INFORMATION

NAME:________________________________

DOB:__________________

DRIVERS LICENSE#__________________________

HAVE YOU HAD ANY TIME LOSS FROM WORK?

0 No D Yes

## AUTO INSURANCE INFORMATION

Yours:

COMPANY:__________________________________

CONTACT: __________________________________

CLAIM NUMBER:

3RD Party Liability:

COMPANY:__________________________________

CONTACT:__________________________________

CLAIM NUMBER:

L&I

ADJUSTER: __________________________________

CONTACT#__________________________________

CLAIM NUMBER:

WAS A POLICE REPORT FILED? ☐ No D Yes

ANY CITATIONS?

## SYMPTOMS

DID YOU HIT ANY PART OF YOUR BODY DURING THE COLLISION? 0 No ☐ Yes

HAVE YOU EXPERIANCED ANY: ☐ Nausea D Confusion D Disoriented D Lighted-Headed D Blurred vision ☐ Ringing in the ears D Dizzy

DID YOU LOSE CONCIOUSNESS? 0 Yes D No

DO YOU REMEMBER THE IMPACT? D Yes D No

WERE YOU AWARE OF APPROACHING COLLISION PRIOR TO IMPACT? 0 Yes O No

ARE YOU CURRENTLY SUFFERING FROM:

D Irritability D Insomnia D Poor Concentration

D Memory Loss .D Restlessness

*DID YOU* GO TO THE HOSPITAL? 0 No ☐Yes

Which? ______________________________

Another health care provider?

Have you ever been injured in a similar manner? D No

☐Yes ______________________________

## ACCIDENT HISTORY

DATE: ---------------------------TIME:______________

HOW DID THE ACCIDENT OCCUR IN YOUR OWN WORDS:-

__________________________________________

__________________________________________

__________________________________________

__________________________________________

WERE YOU DRIVING? D Yes D No

WERE YOU LOOKING STRAIGHT AHEAD? D Yes D No

If not where__________________________

WAS IT YOUR CAR?☐ Yes D No Who's?______________

OTHER PEOPLE IN THE CAR:

1. ______________________________
2. ______________________________
3.

WAS YOUR CAR STOPPED AT THE TIME OF IMPACT?

D Yes, Was the driver's foot on the brake?_____ _

D No, How fast was the vehicle moving?_____ mph

IF YOUR VEHICLE WAS MOVING AT THE TIME OF IMPACT WAS IT, D Traveling at a steady rate of speed D Slowing down D Accelerating

POSTED SPEED______________YOUR SPEED______________

WAS THE OTHER CAR MOVING DURING THE COLLISION?

D No D Yes Approximate speed_____________

IF THE OTHER VEHICLEWAS MOVING AT THE TIME OF IMPACT WAS IT, D Traveling at a steady rate of speed D Slowing down D Accelerating

WERE YOU WEARING YOUR SEATBELT? D Yes D No

WAS IT: D Daylight D Night D Dusk D Dawn

WERE YOU TIRED? D Yes D No

HOW LONG HAD YOU BEEN IN THE CAR FOR?____ _

WHAT WERE THE WEATHER CONDITIONS _ _ _ _ _ _ _

TYPE OF ROAD D Two Lane D Four lane D Gravel D Paved

## DAMAGES

YOUR VEHICLE MAKE/MODEL:______________________

WHAT AREA OF YOUR VEHICLE WAS DAMAGED:.____ _

__________________________________________

WHAT IS THE ESTIMATED COST DAMAGE TO THE VEHICLE YOU WERE IN?__________________

DID YOUR VEHICLE STRIKE ANYTHING ELSE?_____________

SIGNATURE____________________________DATE_ ________