

AUTOMOBILE ACCIDENT INFORMATION

Name: _____

Today's Date: ___/___/___

ACCIDENT DETAILS:

Date of Accident: ___/___/___ Time of Day: _____ AM PM Location of Accident: _____

_____ City or town in which accident took place: _____ State: _____

Were you a Driver Passenger Pedestrian

Were you struck from Behind Right Side Left Side Front

Were you looking straight ahead, to the left, or to the right? Straight Ahead To the Left To the Right

Was your vehicle stopped to make a turn stopped for a traffic signal parked moving at the time of impact

Other: _____

Did your body strike anything in the car? YES NO Describe in detail: _____

Were you wearing a seat belt? YES NO

Describe in detail how the accident occurred: _____

Were you rendered unconscious as a result of the collision? YES NO

Were you taken to the hospital after the accident? YES NO By ambulance or private car? _____

Were you taken to the hospital *immediately* after the accident? YES NO

If not, how much time had elapsed before you went to the hospital? _____

Which hospital were you taken to? _____

Have you been x-rayed since the accident? YES NO If so, where? _____

Have you lost any days of work as a result of the accident? YES NO If yes, how many days have you lost? _____

Have you ever been in a previous auto accident? Describe all instances, giving approximate dates of the accidents, as well as the injuries sustained.

Date	Injuries sustained
___/___/___	_____
___/___/___	_____

-OVER-