AUTOMOBILE ACCIDENT HISTORY

PERSONAL INFORMATION

NAME:_____

DOB:_____

DRIVERS LICENSE #_____

HAVE YOU HAD ANY TIME LOSS FROM WORK?

☐ No ☐ 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 ☐ Yes _____

ANY CITATIONS? _____

SYMPTOMS

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

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

DID YOU LOSE CONCIOUSNESS? ☐ Yes ☐ No

DO YOU REMEMBER THE IMPACT? ☐ Yes ☐ No

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

ARE YOU CURRENTLY SUFFERING FROM:

☐ Irritability ☐ Insomnia ☐ Poor Concentration ☐ Memory Loss ☐ Restlessness

DID YOU GO TO THE HOSPITAL? ☐ No ☐ Yes

Which? _____

Another health care provider?_____

Have you ever been injured in a similar manner? ☐ No ☐ Yes _____

ACCIDENT HISTORY

DATE:_____ TIME:_____

HOW DID THE ACCIDENT OCCUR IN YOUR OWN WORDS:-

_____

_____

_____

_____

WERE YOU DRIVING? ☐ Yes ☐ No

WERE YOU LOOKING STRAIGHT AHEAD? ☐ Yes ☐ No

If not where _____

WAS IT YOUR CAR? ☐ Yes ☐ No Who's? _____

OTHER PEOPLE IN THE CAR:

1. _____
2. _____
3. _____

WAS YOUR CAR STOPPED AT THE TIME OF IMPACT?

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

☐ No, How fast was the vehicle moving? _____mph

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

POSTED SPEED _____ YOUR SPEED _____

WAS THE OTHER CAR MOVING DURING THE COLLISION?

☐ No ☐ Yes Approximate speed _____

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

WERE YOU WEARING YOUR SEATBELT? ☐ Yes ☐ No

WAS IT: ☐ Daylight ☐ Night ☐ Dusk ☐ Dawn

WERE YOU TIRED? ☐ Yes ☐ No

HOW LONG HAD YOU BEEN IN THE CAR FOR?_____

WHAT WERE THE WEATHER CONDITIONS _____

TYPE OF ROAD ☐ Two Lane ☐ Four lane ☐ Gravel ☐ 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 _____