

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 EXPERIENCED ANY: Nausea Confusion

Disoriented Lighted-Headed Blurred vision

Ringing in the ears Dizzy

DID YOU LOSE CONCIUSNESS? 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 _____