ACCIDENT INFORMATION

Date of Accident_____/_____/_____ **Time of Accident**____:____ AM PM

Explain in DETAIL HOW AND WHERE the accident occurred_____

_____

_____

What area of the vehicle was struck? Front Rear Passenger Side Driver Side

What was the posted speed limit? _____MPH

What is the model of vehicle you were in? _____

What is the model of the other vehicle? _____

Did you see the accident coming? YES NO **Did you have your seat belt on?** YES NO

Where you the: DRIVER PASSENGER FRONT SEAT or PASSENGER BACK SEAT of the Vehicle

Where you conscious at all times? YES NO Not Sure **Did the air bags go off?** YES NO

Were you able to get out of the car and walk? YES NO

State which areas of your body hurt immediately after: _____

Was an ambulance called for you? YES NO **Did you go to the hospital?** YES NO

Name of hospital_____ **How long were you there?** _____

What was done? X-Rays Exam Medication **Did you see any doctors?** YES NO

What discomfort did you have the first evening? _____

Were you able to sleep that night? YES NO

Did you have any discomfort the next day? YES NO **If so, what and where?** _____

If you did NOT see a doctor that day, have you since the accident? YES NO **If yes, Where?**_____

CIRCLE any that applies from the time of the accident until now:

Eyes Ears Face Dizziness Sweating Difficulty Swallowing Nasal Disturbances
Chest Disturbances Unconsciousness Headaches Insomnia Restlessness Numbness
Mood Changes Symptoms of arms of legs Tingling Difficulty Moving Inability to void